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NEW JERSEY OVERDOSE PREVENTION ACT:
POLICE OFFICERS' EXPERIENCES AT A DRUG OVERDOSE SCENE

By

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A DISSERTATION

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ABSTRACT

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July 2020
Educational Leadership

NEW JERSEY OVERDOSE PREVENTION ACT: POLICE OFFICERS' EXPERIENCES AT A DRUG OVERDOSE SCENE

The number of drug overdose deaths in the United States from opioids has led to national attention about the problem commonly described as the “opioid epidemic.” Federal and state policymakers have shifted from a hardline punitive approach to a rehabilitative approach in an attempt to save lives. Good Samaritan Laws (GSLs) and advances in medicine have been implemented differently in different states. For example, the enactment of the New Jersey Overdose Prevention Act (NJOPA) and the use of naloxone by first responders are ways that state officials try to save lives. However, there is limited research on the first responders’ experiences, specifically the police officers’ experiences, who administer naloxone and follow the NJOPA. Therefore, the purpose of this transcendental phenomenological study was to understand the lived experience of police officers who have responded to a drug overdose call, and administered naloxone since the passing of the NJOPA and identify common themes among those experiences. Two research questions guided this study: (1) Are there common lived experiences of police officers who responded to a drug overdose call since the passing of the NJOPA? (2) How do police officers describe their workplace/procedures following the implementation of the NJOPA? Semi-structured interviews were conducted with 10 police officers who administered naloxone to a drug overdose victim since the passing of the NJOPA.

Data analysis followed Moustakas' (1994) three step process: Epoche, Transcendental-Phenomenological Reduction, and Imaginative Variation. Five themes emerged from this study: (1) NJOPA and naloxone; (2) change in police procedures; (3) relationship between police officers' attitudes and their years of service; (4) factors that change the experience of an overdose call; (5) police officers and overdose victims after an overdose call. Results showed that, although each police officer's experience is unique at a drug overdose scene, common themes were shared among them such as attitudes towards the victim, perceived attitudes from the victim, opinions on the NJOPA, workplace and overdose environment similarities, and the overall effectiveness of naloxone. Recommendations to policymakers and police chiefs include funding for preassembled naloxone, not allowing a victim to refuse medical attention (RMA), repercussions of some kind to the victim (but not incarceration), informing the public about the NJOPA, training in the police academy, and annual professional development training.

Key words: *Opioid Overdose, Good Samaritan Law, New Jersey, Naloxone, Police Officer, Transcendental Phenomenology*

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Educational Leadership

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July 10th, 2020

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DEDICATION

To the men and women of law enforcement who lost their lives in the line of duty.

To the men and women of law enforcement who continue to honorably protect and serve.

To my wife, Soo Lin

Thank you for your constant love and encouragement throughout this journey.

You are always by my side.

To my children, Scarlett and Sadie

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To all the participants of my study, thank you for sharing your lived experiences with responding to a drug overdose call and administering naloxone since the passing of the NJOPA. Your participation will impact academic literature and policymaker decision-making.

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CHAPTER 1

INTRODUCTION

According to the Center for Disease Control and Prevention (2019), more than 700,000 people died from drug overdoses between 1999-2017. More than 350,000 of these deaths were related to either an illicit or legally prescribed opioid (Seth, Scholl, Rudd, & Bacon, 2018; Center Disease Control [CDC], 2019). Opioids are defined as a class of drugs that includes the illegal drug, heroin; synthetic opioids, such as fentanyl; and legal pain relievers available by prescription, such as hydrocodone, codeine, morphine, and many others (National Institute on Drug Abuse [NIDA], 2019). An opioid is a chemical substance that reduces pain, which binds to receptors in the brain and central nervous system (Lavelle, 2014).

The opioid epidemic can be explained in three waves of the rise in opioid overdose deaths: Wave 1: Prescription opioid overdose deaths; Wave 2: Heroin overdose deaths; Wave 3: Synthetic opioid overdose deaths ([CDC], 2019) (See Appendix A). In 2017, 17,029 overdose deaths occurred from prescription opioids, 15,482 overdose deaths occurred from the illicit drug, heroin, and 28,466 overdose deaths from synthetic opioids other than methadone (Scholl, Seth, Kariisa, Wilson, Baldwin, 2018). Opioids kill people when the receptors in the brain change the behavior of the cells in ways that can slow or stop breathing (Sanders, 2018). In many areas, prescription narcotics are just as, if not more likely, the cause of overdoses than heroin because it is purer, safer, and easier to get (Lavelle, 2014).

An epidemic is defined as the “outbreak of disease that spreads quickly and affects many individuals at the same time” (Merriam-Webster. (n.d.)). The CDC defines the term as an increase in the number of cases of a disease above what is normally expected in that population ([CDC], 2012). Because the CDC definition is based on norms, this paper agrees with Buchman,

Leece & Orkin (2017) in defining the opioid epidemic as the current level of population harms to include deaths related to opioids. For the purpose of the historical context of this research problem, data provided from federal agencies like the Center for Disease Control and Prevention (CDC) and federal institutions like the National Institute on Drug Abuse (NIDA) will provide data that shows how this epidemic affects the United States as a whole. This specific research focuses on the State of New Jersey's response to a national epidemic that includes death totals from all 50 states in the country. As will be discussed, due to the nature of our governmental system, each state has the authority to legislate and promulgate its own laws to combat the opioid epidemic in a way that it sees fit. A historical context from a national problem will be narrowed down to the specific context of a state problem and its response to it – the New Jersey Overdose Prevention Act (NJOPA).

Unprecedented overdose death totals recorded at such high levels throughout the country resulted in local discussion and national attention to a problem commonly referred to as the “opioid epidemic.” ([CDC], 2012). The once common phrase, “war on drugs,” is seldom used compared to the phrase “opioid epidemic.” The beginning of the “war on drugs” is credited to President Richard Nixon in 1971 when he stated that drug abuse is public enemy number one (Coyne & Hall, 2017). On average, over 115 Americans die every day from an opioid overdose (Rudd, Aleshire, Zibbell, & Gladden, 2016; [CDC], 2019). As a result, the philosophy to combat the problem of drug use has changed. Policymakers and politicians across the country have shifted from a hardline punitive approach to a rehabilitative approach in an attempt to save lives (Congressional Documents & Publication [CDP], 2015, 2016; Davis, Webb, & Burris, 2013).

Some of the ways that policymakers decided to combat the opioid epidemic through policy were with the implementation of Good Samaritan Laws (GSLs) and the use of naloxone

on overdose victims by first-responders. A Good Samaritan Law is not a specific law recognized nationally, but, rather a generalized term used to describe a law created by individual states that addresses people who need medical assistance in some way. GSLs were implemented at the state level at times throughout the different waves of the opioid epidemic. Many GSLs were created to help drug overdose victims who need medical attention, however, other GSLs like that in Minnesota, require that a person “shall give reasonable assistance to the exposed person” (604A.01, Minnesota Good Samaritan Law). This actually requires that a person call 911 for any person who needs medical assistance, such as someone involved in a drug overdose, or even something unrelated to drugs such as car crash or heart attack. In some states like Minnesota, a GSL is actually referenced as a “Good Samaritan Law” (604A.01, Minnesota Good Samaritan Law). In other states like New Jersey, GSLs may hold the official title, “New Jersey Overdose Prevention Act” and be slightly different than other state GSLs in some ways (Hoffman, 2013). GSLs vary by state, but the overarching theme among all of them is that they want to encourage someone to provide assistance to someone else in need, in hopes of saving a life.

Naloxone is a medication used to block the effects of opioids, by reducing respiratory and mental depression. It can be administered in various ways to the victim but is most often administered intranasally by police or other first-responders on scene of an opioid overdose (Lavelle, 2014; Wermeling, 2015). It has become standard practice for many police officers to now carry naloxone, just like they would oxygen and an automated external defibrillator (AED), to save the life of an overdose victim.

In New Jersey, the State legislature cannot make something into law, such as carrying naloxone by first-responders, that requires a tool or equipment unless it is paid for by the State. Such unfunded mandates are generally prohibited by the New Jersey State Constitution and

statute (N.J. Const. Art. VIII, § II, ¶ 5 and N.J. Stat. 52:13H-1 *et seq.*). As a result, only “guidelines” or “policies” are set by the State Attorney General’s Office and/or the County Prosecutor’s Office in regards to the use and carrying of naloxone. As outlined above, New Jersey is not required to pay for the cost of buying each agency naloxone unless it is funded, and therefore, some agencies may still not carry it in their patrol vehicles. This researcher is unaware of any police agencies that do not carry naloxone within the county of the researcher’s employment as a police officer. However, the agency of this researcher only has a set number of naloxone kits that were provided through grants and private donations. There have been many instances when all of the naloxone kits are signed out and used by other police officers already on patrol, and therefore, the researcher has gone on patrol without a naloxone kit.

Agencies may get naloxone from national naloxone advocacy groups, like the North Carolina Harm Reduction Coalition (NCHRC) and other local grassroots organizations, private donations from citizens or corporations, etc. and thus the data on how many departments in the country have naloxone is not always up to date. Furthermore, as stated above, simply because an agency may list having naloxone kits, it may be an insufficient amount based on the number of police officers on patrol and the number of residents in the community to be served.

In New Jersey, the New Jersey Overdose Prevention Act (NJOPA) was signed in 2013 by Governor Chris Christie. While the law has been amended several times since its introduction, its initial function was to provide immunity of prosecution of any kind (indictable offense, disorderly person offense, local ordinance) when a person or persons are found in possession or being under the influence of a Controlled Dangerous Substance (CDS) when the police are called to an overdose scene (Hoffman, 2013). In 2015, there was an amendment to the NJOPA that protected first-responders from being held liable when they administered naloxone to drug

overdose victims. Although the NJOPA does not require police departments to carry naloxone, it does protect any officer who administers it from a department where naloxone is carried (Davis, 2015). Therefore, the NJOPA is a good example of a law created by policymakers and politicians that addresses this new approach to combating the opioid epidemic.

However, the effectiveness of any law should be examined to determine if it is a success or not and whether the law achieved its goals. The number of deaths resulting from drug overdoses can be quantified and run through a multivariate analysis to determine if that number has increased or decreased as a result of the NJOPA. Yet, there may be unintended consequences since the passing of the NJOPA that would not show up on a stat sheet such as the concept of moral hazard theory.

Moral hazard theory is traditionally applied to the insurance industry in the economic field, but applies the concept that an individual acts in riskier behavior because they are insured and covered financially (Mirrlees, 1999; Rowell & Connelly, 2012). This concept can also be applied to the healthcare industry and criminal justice field. Therefore, when approaching the opioid problem through the lens of a moral hazard theory, perhaps the NJOPA has decreased the fear of arrest and dying to the point that there is actually an increase in riskier behavior, drug use, and criminal activity. Moreover, there may be problems and/or solutions to the opioid epidemic that are not identified through quantitative research.

This researcher was drawn to combating the opioid epidemic due to friends and family who have either lost their life due to an opioid overdose, or who are currently trying to stay sober. Additionally, and more specifically, this researcher is interested in analyzing the NJOPA from a qualitative perspective of the first-responder due to past and present experiences resulting from actively being a police officer in New Jersey and having to respond to drug overdose calls

since the passing of the NJOPA. These experiences and motivations combined with the limited literature on the lived experiences of the first-responders who are affected by these laws is the impetus for this study.

Background

The opioid epidemic in the United States of America has led to a change in tactics from the criminal justice system as to how to treat individuals who overdose on drugs ([CDP], 2015, 2016; Davis et al., 2013). In an attempt to combat this relatively new phenomenon, policymakers and politicians at the state and local level have created Good Samaritan Laws (GSLs) that vary between states and shift the approach from a punitive to a more rehabilitative approach. As stated above, the predominant goal of all GSLs throughout the country is to save lives. In some instances, depending on the individual state GSL, this includes providing immunity to the overdose victim themselves from criminal prosecution, or requiring a bystander to call 911 for medical attention, regardless of the circumstances.

The use of naloxone was first put into effect in 2010 and has become almost a standard practice by state and local police. The first police agency in the United States that used naloxone was through a pilot program in Quincy, Massachusetts (Davis, Ruiz, Glynn, Picariello, & Walley, 2014). Since this pilot program, it has become the norm for police officers to carry and administer naloxone to overdose victims (Davis et al., 2013; Davis et al., 2014; Davis, 2015). The Office of National Drug Control Policy has stated that naloxone “should be in the patrol cars of every law enforcement professional across the nation” (The White House [TWH] 2013, p.1).

However, until the federal government makes carrying naloxone by first-responders a law, it is up to state and local governments to create their own response to the opioid epidemic. The politicians and policymakers of New Jersey made it clear that they want to follow this

national trend in this approach to combating the opioid epidemic when Governor Christie signed the NJOPA into law in 2013. This law provided criminal immunity to anyone who calls the police to seek medical attention during an overdose (to include the overdose victim themselves) and was recently amended to provide legal protection to first-responders who administer naloxone to an overdose victim (Davis, 2015).

In 2014, New Jersey Governor Christie announced the formal launch of a pilot program in Ocean and Monmouth counties that trained and equipped police officers to administer naloxone to overdose victims (N.J. DL&PS, 2014). During this time, Governor Christie stated, “The nation’s ‘*War on Drugs*’ has been a dismal failure...Unless we recognize and call out the failures of the system and remove the stigma of dealing with addiction for what it really is – a disease – we won’t make progress” (N.J. DL&PS, 2014). Political attitudes like this between the legislature and governor in New Jersey are what led to a different approach in New Jersey in combatting the opioid epidemic, specifically by enacting the NJOPA and the amendments to it that allow for the use of naloxone by first-responders.

The opioid epidemic and the current trend in combatting this problem with GSLs and naloxone by first-responders are the general areas under study. The NJOPA is one of the specific laws that addresses both GSLs and the use of naloxone by first-responders. Limited studies explore the use of GSLs and naloxone from a mixed-methods approach that look at overall figures and data. Other qualitative studies address the problem from the perspective of the drug user or medical professional perspective. Yet, a review of the literature shows significant gaps in the research regarding one of the main stakeholders affected by the NJOPA and similar laws - first-responders. The limited literature on the lived experience from the

perspective of the first-responder, specifically the police officer and paramedic, can be expanded by contributions from this study.

Statement of the Problem

This researcher presents a problem backed up by a summary of recent relevant research, and provides a background of the problem (Roberts, 2010). The societal problem that drives this study is the opioid epidemic, specifically that drug overdose death numbers continue to rise. In 2017, drug overdose deaths resulting from opioids were six times higher than in 1999 ([CDC], 2019). In New Jersey specifically, there were 2,737 drug-related deaths in 2017, compared to only 1,223 drug-related deaths in 2012 (New Jersey Department of Law & Public Safety [NJDLPS], 2019) The problem of the study, more specifically, is the lack of research on police officers' and paramedics' perceptions and experiences of the current approach to treatment in New Jersey (NJOPA). Therefore, this study investigated the lived experiences of police officers who respond to drug overdoses following the passing of the NJOPA. Information gathered from this study can provide new knowledge as to how the approach of combatting the opioid epidemic through a law such as the NJOPA from the perspective of a first-responder is perceived.

Purpose of the Study

The purpose of this transcendental phenomenological study is to understand the lived experience of first-responders who have responded to a drug overdose call since the passing of the NJOPA and examine common themes among them, and specifically, their perceived effectiveness that may contribute to the literature in the opioid epidemic topic. Previous research suggests that areas in the country that have Naloxone Access Laws (NALs) have seen a decrease in opioid related deaths by 9-11% when first adopted (Rees, Sabia, Argys, Latshaw, & Dhaval, 2017). Further examination in the same study shows that the number of opioid related deaths has

had a 21% reduction after two years of NALs in these areas, but for heroin specifically, that number remained statistically insignificant (Rees et al., 2017). This may be due to other factors such as synthetic opioids like fentanyl ([CDC], 2019; Rudd et al., 2016).

Moreover, Doleac & Mukherjee (2018) found that broadening naloxone laws led to more emergency room visits and more opioid related theft, with no reduction in opioid related mortality. This is another reason for the need to understand the lived experiences of police officers and first-responders. The research on this topic is broad and contains many mixed methods and quantitative studies, but there is no research that addresses the lived experiences of first-responders who provide medical care and criminal immunity to overdose victims since the passing of the NJOPA. The purpose of this study addresses that problem and sought to answer the research questions below.

Research Questions

The primary focus of this research exploration is to discover the shared lived experiences of police officers and paramedics who have responded to drug overdose calls since the passing of the NJOPA. Therefore, the following research questions are sought to be answered:

RQ1: Are there common lived experiences of police and paramedics who have responded to a drug overdose call since the passing of the New Jersey Overdose Prevention Act?

RQ2: How do police officers and paramedics describe their workplace/procedures following the implementation of the New Jersey Overdose Prevention Act?

These questions provide a baseline for capturing how police officers and paramedics feel about their experience of handling a drug overdose call and could provide possible common themes among the participants that can be useful in examining the NJOPA.

Conceptual Framework

One of the definitions of the “conceptual framework” is a lens through which the research problem is viewed and it may consist of being a theory, construct, or a research perspective (Roberts, 2010). The conceptual framework provides boundaries for the study and limits the scope of the study. The framework also determines which key material to use in the study’s design and methods, which results in clarity for the reader (Roberts, 2010). It is not possible to study everything within a research topic. This researcher’s academic background in criminal justice and professional background as a current police officer, who has responded to drug overdose victims since the passing of the NJOPA, was a stimulus for this study and is what controls the scope of this study. These personal experiences have helped shaped the conceptual framework for this study. This study was not viewed through the perspective lens of a politician, a prosecutor, a doctor, or a drug overdose victim. It was specific to first-responders impacted by the NJOPA, specifically, police officers and paramedics. The goal is for this information to be examined by all of the stakeholders involved in this field when determining different ways to combat the opioid epidemic.

There is no concrete definition of what a conceptual framework is within the academic community. Ravitch & Riggan (2016) themselves admit that they have found multiple definitions of a conceptual framework when discussing it among professionals in the field and in reading other publications. With that noted, Ravitch & Riggan (2016) still attempt to define a conceptual framework as, “an argument about why the topic one wishes to study matters, and why the means proposed to study are appropriate and rigorous” (p. 5). Furthermore, they argue that a conceptual framework is made up of three primary elements: personal interests, topical research, and theoretical frameworks (2016).

Personal interests. Personal interests and professional goals are shaped by the researcher's "identity and positionality." This is the reason that inspires the researcher to conduct his research. This researcher's identity and position as a police officer allows for him to have a specific perspective on the problem and identify with the phenomena of providing medical care to drug overdose victims. This researcher's own curiosities, biases, and epistemological assumptions are influenced by social location, institutional position, and life experiences. In some instances, what constitutes an important research question might have less to do with the state of the literature on a given topic and more to do with concerns from the researcher himself that are derived from his positionality (Ravitch & Riggan, 2016). In this study, the personal interests and positionality of the researcher explain the reasoning for not only the broad topic of the opioid epidemic, but also the specific law in New Jersey - NJOPA

Topical research. Topical research is research that identifies the topic within a broad set of terms. It can consist of primarily academic journals and books, but can also come in the form of federal, state, and local government laws, policies, and practices. Reports produced through foundations, nonprofits, and advocacy groups would also classify as means of topical research (Ravitch & Riggan, 2016). The research in the topic of opioid epidemic is abundant and covered from most perspectives, including the medical and governmental perspectives. However, the lack of literature documenting the lived experiences of the first-responders that deal with this topic is what helped determine this conceptual framework.

Theoretical framework. The term theoretical framework is often used interchangeably with the term conceptual framework, and rarely a difference is made (Roberts, 2010). However, Ravitch and Riggan (2016) argue that the conceptual framework serves as the "superstructure" for the work and that the theoretical framework is found within the conceptual framework

through the literature review process and helps connect the gaps between the two (p. 9). The theoretical framework aims to advance the argument beyond where previous researchers have taken it. Based on this researcher's literature review, identity and positionality, and developed conceptual framework, a theoretical framework considering moral hazard theory was applied for this phenomenological study.

Moral hazard theory applies the concept that an individual acts in riskier behavior because they are insured and covered financially (Mirrlees, 1999; Rowell & Connelly, 2012). This theory has been applied to various industries and studies have been conducted on topics such as public health care versus private health care doctor visits (Moore, 2016), riskier driving behaviors by insured car drivers (Cohen & Dehejia, 2004), and riskier behavior resulting from the implementation of seat belts (Peltzman (1975). Chapter 2 and Chapter 3 further address the conceptual and theoretical framework discussed in this section, but it is this economic-based theory that has been applied to the criminal justice field and this topic of the NJOPA.

Limitations

This transcendental phenomenological study has inherent limitations and delimitations. A limitation is a factor that is out of the control of the researcher that may affect the study in a certain way (Ravitch & Riggan, 2016). As with most qualitative studies, and due to its methodological nature, a natural limitation of this study is that the sample size is small. It was the goal of this study to engage between 8-14 participants. This is a naturally occurring aspect of this type of study and aligns with the methodology itself. Therefore, it cannot be generalized to a larger population. However, this is not the goal of this study. The goal is to explore and discover common themes derived from first-responders that have responded to a drug overdose call since the passing of the NJOPA.

Delimitations

Unlike a limitation, a delimitation is something that the researcher can control such as time, place, participant selection characteristics, etc. in order to address the purpose of the study (Bloomberg & Volpe, 2012; Roberts, 2010). Because the researcher is currently a police officer, the first core process that aids in the derivation of knowledge in transcendental phenomenology, Epoche, was completed. Epoche is the idea that the researcher will refrain from judgments and their everyday understandings of this phenomena, but rather, take a fresh, naïve approach to the topic (Moustakas, 1994). Throughout this study, Epoche was utilized because of his full-time career as a police officer working with the overdose victims under the NJOPA. A reflection journal was kept by this researcher in an attempt to aid in the reduction of his preconceived judgments. Another delimitation of this study is that participants who worked at the same agency as this researcher were excluded from participation in this study. This was done intentionally to avoid conflict of interest for not only the participants, but the researcher as well.

This study was to be conducted within three centralized counties within the State of New Jersey. This was due in part to the researcher's access to these sites through chiefs of police and paramedics. This adds to the delimitations. A final delimitation of this study is that this study was intentionally narrowed down from all first-responders to only police officers and paramedics. Other common first-responders include firefighters and EMT's, but due to the site location of this study (New Jersey), most firefighters and EMT's are volunteers and are not the first on location (Mikle, 2014). It was also possible that with the use of snowball sampling, that there would be more police officer participants than paramedics and vice versa. With the onset of COVID 19, paramedics were unable to participate in the study, so the final data set reflects only police officers.

Trustworthiness

Although this study cannot be generalized to a larger population, it can still be useful and applied to other police and paramedics in similar counties within the State of New Jersey. Furthermore, this study can apply to any state or local government that is considering or has similar laws on the books like the NJOPA. This makes this study transferable, which adds to its overall trustworthiness. “Transferability refers to the fit or match between the research context and the context as judged by the reader” (Bloomberg & Volpe, 2015, p. 164). The first factor of detailed information concerning the background/context of the topic and the second factor of thick and rich descriptions included in the study, help offer an element of shared experience and an overall increased level of trustworthiness (Bloomberg & Volpe, 2015). It is up to the investigator to provide enough descriptive data to make transferability possible (Merriam, 2009). This researcher provided that descriptive data.

Scope and Assumptions

Data from participants were examined for common themes that emerged and to contribute to the literature in the opioid epidemic topic from a unique perspective. The site location of this study is central New Jersey and consisted of participants from three counties. The geographical makeup of these three counties is diverse and consists of urban cities and rural towns. The socio-economic makeup is also diverse and the study location ranges from low-income areas to high-income areas. Although this study location contains areas that are representative of the State of New Jersey as a whole, it is still worth noting that the areas from within the counties where the participants actually reside was not determined before inclusion in the study. It should also be noted that central New Jersey counties, although in many ways similar, are still unique and different to northeast counties bordering New York City, southwest

counties bordering Philadelphia, and eastern shore counties bordering the Atlantic Ocean. The three counties that make up the site location within New Jersey combine for over 1.2 million people, over 1,000 square miles, and have an average household income of over \$50,000.

Assumptions of this research project are that all participants in this study answered all of the interview questions openly and honestly.

Rationale

The rationale for this study was to initially examine the NJOPA and conduct a policy analysis to determine if this law was achieving its stated goal. This idea stemmed from the researcher's professional experiences as a police officer and his curiosity based on his lived experiences in working to address this phenomena. However, through the literature review process, it was discovered that there were relatively few phenomenological studies conducted addressing the topic of the opioid epidemic. Some studies showed the experiences of women entering methadone treatment (Rubio, 2016), while others examined the drug users' experiences receiving different treatment options (Coltea, 2016; Ouzounian, 2018). There were even phenomenological studies on the experiences of heroin users' arrest experiences (Bardon, 2018) and of opioid users who administered take-home naloxone (McAuley, Munro, & Taylor, 2018). Due to the limited literature on experiences of police and paramedics who respond to drug overdose calls in a state like New Jersey that has the NJOPA, as well as other ethical and Institutional Review Board (IRB) privacy and protection issues concerning this researcher's full time job and research topic, it was determined that this was the appropriate lens for the study.

Significance

The significance of this research is that it will contribute to the academic literature in this field that lacks data and research around lived experiences of first-responders. When examining

research on a topic as broad, yet contemporary and significant, it is important to examine different perspectives from all stakeholders involved. Quantitative, qualitative, and mixed-methods studies are all relevant and should all be considered when trying to help solve this problem. Therefore, this study is not only significant to the academic community, but it could be used by New Jersey policymakers and politicians when examining the affects and/or unintended consequences of the NJOPA. Furthermore, this study can provide another perspective from the first-responders to all policymakers across the country and/or world who are thinking of combatting the opioid epidemic with a law like the NJOPA.

Definition of Terms

The following key terms are defined below and listed in alphabetical order with no hierarchical order:

Controlled dangerous substance (CDS). Any drug, substance, or immediate precursor listed in the Schedules I through V. This means almost any drug that one can use to alter one mentally. This even includes drug analogs, which have a chemical structure similar to a controlled dangerous substance and produce a similar effect (N.J. Statute 2C:35-2).

Disorderly person offense. In New Jersey, an offense that is less serious in nature when compared to an indictable offense and that does not require the support of a grand jury to formally charge a person. In other states, it is often referred to as a misdemeanor.

Drug overdose. An acute condition including, but not limited to, physical illness, coma, mania, hysteria, or death resulting from the consumption or use of a controlled dangerous substance or another substance with which a controlled dangerous substance was combined and that a layperson would reasonably believe to require medical assistance (NJ Senate, No. 677).

First-responder. A person with specialized training who is among the first to arrive on scene to provide aid in emergency situations.

Good Samaritan Law (GSL). A law that provides criminal immunity to the callers of 911 that seek medical assistance for an overdose victim. Specific GSLs vary by state.

Indictable offense. In New Jersey, an offense that is more serious in nature compared to a disorderly persons offense and that requires a grand jury to review the case and find enough evidence to support a formal charge. In other states, it is often referred to as a felony.

Paramedic. A permanent or full-time employee in the State of New Jersey who is state certified to perform advanced life-saving (ALS) procedures and who is employed by a state approved agency.

Police officer. A permanent and full-time sworn employee in the State of New Jersey who holds a certificate in Basic Course for Police Officer from the New Jersey Police Training Commission and who is employed by a law enforcement agency. Law enforcement agency can include state, county, and local level agencies.

Naloxone. A medication that is used to block the effects of opioids, by reducing the respiratory and mental depression. It can be given intravenously or injected, but it is most often administered intranasally by first-responders. It is also most commonly referred to by its brand name Narcan (Lavelle, 2014; Wermeling, 2015).

New Jersey Overdose Prevention Act (NJOPA). New Jersey law signed by Governor Chris Christie in 2013 that provides immunity of prosecution of any kind (indictable offense, disorderly person offense, local ordinance) when found in possession or being under the influence of a Controlled Dangerous Substance (CDS) when police are called to an overdose scene (Hoffman, 2013). *See Appendix B*

Opioid. A class of drug that includes the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription such as hydrocodone, codeine, morphine, and many others ([NIDA], 2019).

Senior police officer. For purpose of this study, a participant who has more than eight years of completed service as a police officer.

Junior police officer. For purpose of this study, a participant who has less than eight years of completed service as a police officer.

Conclusion

The opioid epidemic is a problem that exists in this country today, and it continues to take lives and tear families apart. Research has shown that overdose deaths have been rising significantly, while at the same time, naloxone has been proven to save lives. The consequences and unintended outcomes of GSLs and the use of naloxone are still being determined. Yet, it is undeniable that the opioid epidemic has social and criminal consequences for all parties involved, including the nation as a whole. However, the recent change in approach by policymakers in this country was brought to light in this chapter. Specifically, the NJOPA was discussed and how the lack of research about the lived experiences of the first-responders that now administer naloxone on overdose victims led to this study.

Attaining a deeper understanding through the documenting of the experiences of the first-responders will not only add to the academic literature on this topic, but it can ultimately influence policymakers and politicians when deciding how to combat the opioid epidemic now and in the future. Chapter 2 will review the literature that exists on the overall topic of the opioid epidemic, breaking down the conceptual framework based on this researcher's identity and positionality, topical research, and theoretical framework. The researcher will present research

and data that exists within these topics, and will identify what is lacking, such as phenomenological studies from the lived experiences of first-responders. Chapter 3 will discuss the methodology of this study, which will include the research design, setting, participants, sample, and questions for the semi-structured interviews. Chapter 4 will present and discuss the findings. Chapter 5 provides an interpretation of the findings and recommendations for application of the results as well as future research.

CHAPTER 2

LITERATURE REVIEW

The purpose of this literature review is to examine the topical research on the opioid epidemic, which includes the relatively new idea in the United States of providing drug overdose victims immunity from prosecution and first-responders now having the ability to save their lives with naloxone, if it is available within that agency. It will also attempt to capture and analyze any phenomenological studies in the academic literature that relate to first-responders' experiences in their approach towards drug overdoses and/or Good Samaritan Laws (GSLs) and naloxone. This literature supports a qualitative study that focuses on the New Jersey Overdose Prevention Act (NJOPA) and the common experiences shared by the police and paramedics servicing New Jersey. The official name of a law varies between states because it is dependent on how their respective legislatures name the law. Therefore, it is important to understand that the NJOPA can in many cases be interchanged with GSLs for purpose of this literature review because they both contain the common goal of providing medical attention to drug overdose victims as quickly as possible to save their lives. A simple search of "New Jersey Overdose Prevention Act" yields minimal results when attempting to capture the broader context and history of the opioid epidemic and state legislature responses to it. Additionally, the limited phenomenological studies of first-responders' lived experiences are better captured through searches that include the broader term Good Samaritan Law than the specific NJOPA.

As an average person in today's society, this researcher is one of the statistics who have personally lost friends to the opioid epidemic. This researcher currently knows people who are alive and abuse opioids, both prescription painkillers and illicit heroin. Over 2 million Americans are addicted to prescription painkillers alone ([CDC], 2019). This researcher

currently has close friends who have lost children from heroin overdoses. This researcher has seen the devastation and sorrow that it has caused to the victims' existing family members and the community. To the average American, one can't help but think that this madness and number of people dying needs to stop.

However, this researcher is also in a unique position to also experience and live through the opioid epidemic from the position of a law enforcement officer. This has led him to see the problems that opioids cause to not only the drug overdose victim's life, but also the innocent people in the community who aren't necessarily friends or family members. It is estimated that the cost of the opioid epidemic for the year 2015 was \$504 billion, which is about 2.8% of the United States GDP (Council of Economic Advisors, 2017). This researcher has also seen the crimes committed by people addicted to drugs to get the money to feed their addictions.

Although violent crimes are not typically associated with drug use (Quinones, 2015), this researcher's lived experience is that there appears to be an increase in nonviolent crimes such as shoplifting, theft, and burglary. MacCoun, Kilmer, & Reuter (2003) find that substance abuse affects crimes in three ways: 1. Leads users to steal to generate income to buy drugs, 2. Has a direct physiological effect making them act erratic, and 3. Creates violence in defending turf/customers. Finally, this researcher has personally saved drug overdose victims' lives by using the opioid reversing drug, naloxone, only to witness them overdose again and/or commit more crime, without being charged for the initial drug overdose offense because of the parameters set fourth within the NJOPA.

Therefore, as someone who has this unique perspective, it is important to consider this research question from someone in the criminal justice field. The experiences of this researcher as a regular civilian, friend of victims, and a police officer also bring an inherent bias, which

must be protected, but also recognized. This researcher's identity and positionality as a police officer may cause some controversy among the general public and policymakers, but it is imperative to ask the question of whether increasing the use of naloxone and not charging overdose victims criminally is having a negative effect on crime and recidivism rates, based on their lived experiences.

To establish a direction for this literature review, a broad search was first conducted on the opioid topic using terms such as "opioid epidemic," "opioid overdose," and "opioid defined." An attempt to explain the history and an account of how the opioid epidemic came to be was researched by using terms such as "opioid crisis" and "origin of the opioid epidemic." These results opened the door for articles that described the national and local attention this problem was receiving from politicians, hospitals and doctors, taxpayers, and first-responders. It is in these research results that GSLs and naloxone are spoken about more often as a new approach to combat this problem. Concepts about and stakeholders in GSLs and naloxone are discussed, which ultimately paved the way for this phenomenological study on the common experiences of police and paramedics.

An important goal of this literature review was to explore the broad topic of the opioid epidemic and hone in on some specific areas that are relevant to this study from a criminal justice and law enforcement perspective. This chapter reviews specific areas of the opioid epidemic that are relevant to understanding the lived experiences of police officers and paramedics. A conclusion section closes this chapter and provides the reader with a compiled list of identified themes and a direction of this research.

Opioid Epidemic

How many drug-related deaths does it take to be considered an epidemic? An epidemic is defined as an increase in the number of diseases than what is normally expected in a population ([CDC], 2012). According to the Center for Disease Control and Prevention (2019), more than 700,000 people have died from a drug overdose from 1999-2017. More than 350,000 of these deaths were related to either an illicit or legally prescribed opioid ([CDC], 2019; Seth et al., 2018). This high number of unprecedented overdose death totals recorded prompted local discussion and national attention to a problem commonly referred to as the “opioid epidemic” as classified by federal agencies like the Center for Disease Control and Prevention. In New Jersey, the Office of the Attorney General created The Office of the New Jersey Coordinator for Addiction Responses and Enforcement Strategies (NJCARES), and categorized the opioid epidemic as the “opioid crisis” (New Jersey Division of Law & Public Safety [NJDLPS], 2019).

In response to the alarming increase in opioid-related deaths, policymakers at the state level within their respective states started to implement the use of naloxone by first-responders and police officers as a way to save lives and lower the death totals beginning in the 2010’s. The first pilot program of police officers using naloxone was completed in Quincy, Massachusetts in 2010 (Davis et al., 2014). Since this pilot program’s success, it has become the norm for most police officers to carry and administer naloxone to overdose victims (Davis et al., 2013; Davis et al., 2014; Davis, 2015). The number carried depends on the amount of naloxone kits an agency was able to secure through private donations or public grants. An increase in Good Samaritan Laws (GSLs) also occurred around this time in other states like New Jersey, in hopes of eliminating the fear of arrest when calling the police for life saving medical care (Hoffman, 2013).

Nevertheless, for every action, there is an equal and opposite reaction. Although there may be a reported increase in lives saved, the same overdose victim could be saved by naloxone multiple times, thus skewing the statistics. For example, in Columbus, Ohio, one overdose victim was saved six times from naloxone due to her friends calling emergency responders and them administering naloxone to save her life (Candisky & Schladen, 2017). Not only does this skew the statistic of how many lives are saved by administering naloxone, it can also lead to something called “compassion fatigue” (Candisky & Schladen, 2017). Compassion fatigue is the idea that naloxone “is being used as a crutch, allowing addicts to continue abusing drugs without consequence,” thus making not only first-responders fatigued, but citizens from the general public asking why naloxone is repeatedly used to save lives of opioid users (Candisky & Schladen, 2017). Examples like this one, paired with this researcher’s experience as someone who has administered naloxone to an overdose victim who is not charged criminally, adds to the reason why “moral hazard theory” is an appropriate theoretical framework for this research. The psychological impact of having naloxone laws in place may decrease the overdose victim’s fear of dying and/or arrest, resulting in riskier behavior and an increase in more drug use or criminal activity.

While the laws vary in each state, the laws that allow overdose victims to be immune from prosecution are often referred to as “Good Samaritan” laws. Surrounding laws, or dependent policies, are often referred to as “naloxone” policies. Naloxone is a drug administered by first-responders, often police, which reverses the effects of opioids, and can save the victim’s life (Lavelle, 2014; Wermeling, 2015). Both laws are implemented and written at the state level and thus, vary accordingly depending on the individual state. For example, the NJOPA does not require that all police agencies carry naloxone, but it does provide criminal and civil immunity

from police officers that do carry and administer naloxone, as well as criminal immunity to the overdose victim (Hoffman, 2013). In some states like Ohio, some policies are set at the county level by the Sheriff and local government, while in other counties within Ohio, officers carry naloxone and do not charge. For example, in Butler County, Ohio, police officers do not carry naloxone, and they can even charge a person who repeatedly overdoses with a misdemeanor for “inducing panic” (Candisky & Schladen, 2017). Nevertheless, there is much topical research concerning the background and creation of these laws by some stakeholders, including those in the medical and political fields. However, there is a lack of research on the effectiveness of these laws and some of the unintended consequences that may arise from repeatedly responding to drug overdose calls and not prosecuting anyone criminally.

The opioid epidemic and the alarming number of deaths attached to it remain an often-discussed topic at both federal and state levels. It is a topic of discussion at the local store, restaurant, and church in small towns that has made its way all the way to the top of national news stations and the latest presidential debate. The opioid epidemic does not discriminate based on one of the “protected classes” and it does not discriminate against socioeconomic or geographical status. Perhaps this is why it has gained much attention and rallied communities and politicians from all parties to come together in an attempt to combat this problem. However, often the opioid epidemic is looked at through the lens of a healthcare perspective and not a criminal justice or law enforcement perspective. The time has come for this problem to be examined through the perspective of the first-responders’ lived experiences who are following guidelines about the implementation of these GSLs and administering naloxone.

Conceptual Framework

Evolving responses to opioid overdoses. Key search terms used to gather information on the topical research include: heroin, opioid, overdose, naloxone, Narcan, first-responder, police, phenomenological study, and moral hazard theory. However, the initial research contains literature on the actual effects of naloxone from a medical perspective. This includes research that proves naloxone is effective at saving lives because it scientifically reverses the effects of opioids when it is administered properly. Initial research results seem to support the fact that naloxone can save lives. Utilizing the National Vital Statistics System (NVSS) from the period of 1999-2014, (Rees, Sabia, Argys, Latshaw, & Dhaval, 2017) found that there was a 9-11% decrease in opioid related deaths due to the adoption of naloxone laws, which were first implemented in New Mexico in 2001 (NM Stat § 24-23-1). Similar to the NJOPA, the New Mexico law, NM Statute 24-23-1, provided civil and criminal immunity to first-responders that administered naloxone to a drug overdose victim. However, unlike present New Jersey law, New Mexico evolved their initial statute and became the first US state to require police officers to carry and administer naloxone to a drug overdose victim in 2017. (Bhatt, Katzman, Duensing, Martinez, & Swift, 2017). In 2014, New Mexico had the second highest overdose death rate in the nation, only behind West Virginia. Although the promulgation of New Mexico's new law does not include any new funding, there is already state funding that exists for each police force in New Mexico based on a per officer rate. In addition to grants, this funding is used to purchase the naloxone kits, at approximately \$70.00 each (Bryan, 2017). Since 2001, almost all of the 50 states have had some type of naloxone laws or policies in place to allow first-responders and/or private citizens to administer naloxone.

The medical professional opinion and scientific fact of naloxone's ability to save lives led to the idea that in order to save more lives, naloxone should be administered by police and paramedics, who are often first on scene during an overdose call (Rando, Broering, Olson, Marco, & Evans, 2015). Again, it is not being disputed that naloxone scientifically saves lives when appropriately administered during an overdose (Health and Human Services [HHS], 2019). There are many sources from government agencies, federal hearings in front of Congress, and local and state policies on not only the opioid epidemic, but the use of naloxone by first-responders. Further examination shows that two or more years after naloxone laws are adopted, opioid related deaths decrease by 21%. However, this is only true for overall opioid related deaths, and when the heroin is looked at specifically, it proves to have a statistically insignificant affect (Rees et al., 2017). This is an interesting finding and suggests more research is needed on the effectiveness of GSLs and naloxone laws, following their implementation and time frame in relation to the widespread use of heroin compared to prescription painkillers.

However, the research that discusses the unintended consequences of saving lives using naloxone is lacking in the present year of 2020. There is one working research paper from Doleac & Mukherjee (2018) titled, "The Moral Hazard of Lifesaving Innovations: Naloxone Access, Opioid Abuse, and Crime" that caused controversy in the medical and political field. The authors found that broadening naloxone laws led to more emergency room visits and more opioid related theft, with no reduction in opioid related mortality. Other evidence suggested that the use of fentanyl was increased by the drug user because of riskier behavior associated with the insurance policy of naloxone laws (moral hazard theory) (Doleac & Mukherjee, 2018). Additionally, the term "compassion fatigue" was discovered during this literature review, which is very similar to the concept of moral hazard theory; it means that naloxone is being used as a

crutch for an overdose victim to keep reusing drugs without any consequences. The result is a lack of compassion by first-responders and members of the general public (Candisky & Schladen, 2017). The question of the moral hazard of lifesaving innovations is a reasonable one that needs to be further researched by professionals in the criminal justice field.

Moral hazard theory. The literature on the topic of naloxone is vast and overwhelming. It was exhaustively examined medically and politically when this life-saving drug became one of the answers to combat the opioid epidemic mostly in the mid 2010's. When this researcher became a police officer in 2009, he saw and was a part of the policy change in the State of New Jersey that required this researcher to use naloxone to save a drug overdose victim's life. The initial thoughts of this researcher were that this would encourage drug overdose victims to use more opioids and commit more crime, caused by a newfound lack of fear of arrest or dying. This researcher thought that an overdose victim who is given an impetus to use drugs without punitive action, and who lives in an unstable environment, would be likely to recidivate and commit crime to feed their addiction.

It was not until completing the literature process that this researcher found the application of moral hazard theory to the use of naloxone and drug abuse and crime. Moral hazard theory is traditionally applied to the insurance industry in the economic field, but applies the concepts that an individual acts in riskier behavior because they are insured and covered financially. Moore (2016) utilizes this theory to examine why Medicaid and Medicare had the significantly highest rate of no shows compared to Blue Cross, United Health, and Health Link, and determined that it was because of the low or no cost of payment within Medicaid that influenced personal responsibility and no shows. Cohen et. al. (2004) found that car insurance incentivizes riskier driving through moral hazard, thus creating more accidents. Peltzman (1975) argued that the

benefits in safety from seatbelts would be offset because of compensatory behavior due to riskier driving, although (Cohen, Alma, & Dehejia, 2003) determined that this moral hazard was small compared to the overall safety from seatbelts. Nevertheless, it is this commonsense thinking using traditional economic theories in the criminal justice field that could allow for this observed phenomenon of unintended consequences of naloxone and the NJOPA, or GSLs, to be explained.

The psychological impact of naloxone laws and GSLs should be examined to determine if it affects a drug overdose victim's thoughts and actions regarding the opioid epidemic.

Statistics in crime and drug recidivism are good indicators to determine if a new policy works, although there are other influences on human behavior as well as unintended consequences. Do the experiences of the first-responders who service a drug overdose victim share common experiences with a common theme? A qualitative phenomenological study of first-responders was considered and chosen to analyze their perceptions about naloxone policies and the NJOPA.

Opioid Defined and Outcomes Unanswered

Opioid is a word that describes a broad array of drugs that can include illegal drugs, such as heroin; synthetic opioids, such as fentanyl; and legally prescribed drugs, like oxycodone, hydrocodone, codeine, and morphine (National Institute on Drug Abuse [NIDA], 2018). Opioids are found naturally in the opium plant or can be created synthetically in a laboratory. Opioids both reduce the perception of pain in individuals and increase one's pain tolerance when the chemical substance binds to receptors in the brain and central nervous system ([NIDA], 2018; Wermeling, 2015). Opioids kill people by slowing down the rate and depth of breathing by activating the opioid receptors in the brain that control these mandatory functions. There is an abundance of research available in the scientific and medical community about opioids and various other drugs, including their origin, creation, medical, and scientific uses. Within the

social science field, the research on the implementation of certain policies and laws and their unintended consequences is limited, possibly due to this being a fairly new phenomenon.

Additionally, there is an ample amount of information regarding opioid deaths and statistics from government agencies, such as the Center for Disease Control and Prevention (CDC) and many county and city Chief Medical Examiner's Office (coroner). Law enforcement government agencies such as the Department of Justice (DOJ), Drug Enforcement Administration (DEA), and Alcohol Tobacco Firearms and Explosives (ATF), release their own statistics on crime and drug related deaths. For the most part, these sources provide data and/or press releases on newsworthy stories like drug seizures at the border or closing down manufacturing facilities to show how they are fighting the "War on Drugs" (Department of Justice [DOJ], 2018).

Information about the opioid epidemic and naloxone use by first-responders by non-government agencies also shows support for the implementation of naloxone by first-responders. The National Association of Drug Diversion Investigators (NADDI) is the leading drug diversion training organization in the nation with the largest networking platform for professionals involved in the field of pharmaceutical drug diversion ([NADDI], 2019). NADDI strongly supports the training for and use of naloxone for overdose victims by police officers, realizing that this will reduce the number of overdose deaths from opioids (Burke, 2012). The research has proven that this response is effective in the short term. The Surgeon General of the United States Public Health Service, VADM Jerome Adams, even stated the importance of the overdose-reversing drug naloxone in its ability to save a life from a legally prescribed opioid to an illicit opioid, such as heroin ([HHS], 2019).

There is also limited research on the benefits of having a “Good Samaritan” law, however, the Department of Health and Human Services recognizes that states have GSLs in place to prevent people from civil and criminal liability who try to save someone’s life in a good faith effort ([HHS], 2019). The problem is that in the year 2018, when opioid deaths were at an all-time high in most places throughout the country ([CDC], 2019; Fanelli, 2018), there did not appear to be much follow-up research in regards to whether these two changes in laws were effective. Furthermore, there is little research done on this topic from the perspective of the police officer or first-responder.

In the early 2000’s, police officers did not carry naloxone in their patrol vehicle, nor did they know what it was or how to use it. Fast-forward to 2020 and many police officers are familiar with naloxone and/or how to administer it. Currently, over 1,200 police departments in the United States carry naloxone (North Carolina Harm Reduction Coalition [NCHRC], 2019). This number is likely higher due to underreporting of the agencies to the North Carolina Harm Reduction Coalition (NCHRC), which is a national naloxone access advocacy group that is a major source for law enforcement agencies to obtain naloxone. Agencies may get naloxone from the NCHRC, other local grassroots organizations, private donations from citizens of corporations, etc., and thus the data on how many departments in the country have naloxone is not always complete.

However, since naloxone policies vary and change by each state and individual police departments, there are some overall questions that should be addressed: Does the implementation of “Good Samaritan” laws increase the chance of saving a drug overdose victim’s life? Does the implementation of police using naloxone to save a drug overdose victim’s life increase the chance of saving his or her life? Does the lack of fear of arrest and dying result in more drug use

and crime committed by the drug user? The following themes and sub-themes on this topic will provide a better understanding of what research is currently available on this topic.

Origin of the Opioid Epidemic

There is no official date as to when the “opioid epidemic” or “opioid crisis” began in the United States, but according to the Center for Disease Control and Prevention (2019), more than 700,000 people have died from a drug overdose between 1999-2017. More than 350,000 of the 700,000 deaths were related to either an illicit or legally prescribed opioid (Seth, Scholl, Rudd, & Bacon, 2018). Since the word “opioid” covers a broad array of drugs, the opioid epidemic can be broken down into three waves since the 1990’s. The first wave began in 1990 with the increase in prescription opioids being written legally by doctors being pushed by drug companies to help Americans with their chronic pain conditions ([CDC], 2019; Kolodny, Courtwright, Hwang, Kreiner, Eadie, Clark, & Alexander, 2015). The second wave is considered to have started in 2010, with the increase in overdose deaths involving heroin ([CDC], 2019). The third wave started in 2013, with a major increase in overdose deaths involving synthetic opioids, specifically, illicitly manufactured fentanyl ([CDC], 2019; Rudd et al., 2016). The data from the National Vital Statistics System Mortality File shows that this is an evolving epidemic that is currently in the third “wave” of its course, which is also known as “Wave 3: Rise in Synthetic Opioid Overdose Deaths” (See Appendix A). The death rates are higher than ever in all three categories and the epidemic is a major topic of discussion among policy makers and the public.

In New Jersey, the third wave of the opioid epidemic is evident. From July 1, 2016 to June 30, 2017, 2,284 people died of drug overdoses, which was a 34.7% increase over the previous fiscal year, according to the CDC (Stirling, 2019). This increase can be attributed to the rise in synthetic opioids like fentanyl. Moreover, the most recent confirmed data on drug

overdose deaths in New Jersey is 3,006 total deaths in 2018 compared to 2,737 deaths in 2017 (N.J. DL&PS, 2020). These statistics are important to understand when discussing the site location of this study.

National Attention

There are several perspectives that are examined by policy makers in regards to combatting the opioid epidemic. Many angles are questioned such as the roles of the drug companies, the pharmacy, the overdose victim, and the police (specifically the Drug Enforcement Administration, DEA). For example, in an Oversight and Investigations hearing in front of Congress in 2018, politicians discussed and examined the problem of opioids with DEA Administrator, Robert Patterson. Politicians acknowledged that the opioid crisis is a grave concern because it was, at the time, the number one cause of unintentional deaths in the United States. Citing economic reasons, Congresswoman DeGette (Colorado) stated that it has led to over \$1 trillion in spending since 2001 (House Energy and Commerce Committee [HECC], 2018). Members of Congress from across the country, wanting to help their constituents in their respective states, came together to examine the State of West Virginia to try and understand why it had the highest death toll in the nation from drug overdoses. West Virginia had over 780 million opioids distributed across their state from 2007-2012, with some drug companies shipping over 22,500 hydrocodone pills in one month ([HECC], 2018). These discussions and findings are from a national hearing in the year 2018 and have resulted from years of opioid problems throughout the nation in all the states.

One of the ways the federal government has addressed the opioid epidemic is through an initiative called the Data-Driven Prevention Initiative (DDPI). The DDPI supports local efforts to end the opioid epidemic by helping states “advance and evaluate their actions to address

opioid misuse, abuse, and overdose” by investing over \$50 million in state health departments to improve data collection and analysis of opioid use, develop strategies that impact behaviors driving prescription opioid abuse, and work with communities to develop an opioid overdose prevention program ([CDC DDPI], 2020, para. 1). New Jersey is one of thirteen states that have received funding since this initiative began in 2016 ([CDC DDPI], 2020).

Local Solutions (Increased Spending/Training and New Laws)

Federal law enforcement can help fight the opioid epidemic at a macro-level by limiting the supply of heroin coming across the border or prosecuting drug companies or manufacturers that break the law. However, the people that work with actual overdose victims regularly are the local police and paramedics. It is the local police officer, paramedic, or EMT who responds to the scene of an overdose and must interact with the victim and/or save his or her life. The increase in overdoses has led to a strain on local municipalities, financially and emotionally. As a result, U.S. Senator Chris Murphy (CT) called for \$240 million in federal funding to help assist local law enforcement and communities fight the opioid epidemic, specifically by improving coordination between criminal justice and substance abuse agencies, setting up community task forces, and funding police in their effort to investigate, locate, and stop illegal use and distribution of heroin and prescription opioids (Federal Information and News Dispatch [FIND], 2016)

Another way to reduce the number of deaths at the local level is to allow greater access to the drug naloxone, which reverses the effects of opioids when administered by police officers or first-responders, thus saving the victim’s life. However, this provision is achieved by more funding from the federal government. In 2015, U.S. Senators Jack Reed (RI) and Dick Durbin

(IL) introduced the Overdose Prevention Act (this is not to be confused with New Jersey's Overdose Prevention Act). The bill would:

...Decrease the rate of drug overdose deaths by improving access to naloxone, a drug that counters the effects of an opioid overdose. Naloxone has no side effects or potential for abuse, and is widely recognized as an important tool to help prevent drug overdose deaths, but many communities struggle to get naloxone to those on the front lines who need it most. The bill would also encourage the implementation of overdose prevention programs, improve surveillance of overdose occurrences, and establish a coordinated federal plan of action to address the epidemic. ([FIND], 2015, p. 1)

The federal government is trying to address the issue of drug overdoses by using taxpayer money to fund the use of more naloxone by first-responders and medical facilities. This idea of using naloxone to save lives of overdose victims started to take shape and hold more validity as a way to combat this problem in the year 2011 when New Mexico became the first state to not hold first-responders who administer naloxone civilly or criminally liable. New Jersey also followed this trend in 2015 but amended the NJOPA to include immunity from civil and criminal liability for first-responders who administer naloxone. This is a different approach to the more common policing philosophy of arrest, prosecute, jail, treat, get clean, and deter.

Ironically, as the demand by politicians at the federal level to use the drug naloxone increases, drug companies are raising prices and increasing profits in the drug overdose industry. Berger (2017) states that, "naloxone was approved by the Food and Drug Administration (FDA) in 1971 for treating opiate overdoses by intravenous or intramuscular injection. The drug has been around for nearly 5 decades, but in recent years policymakers and physicians have noticed a

troubling trend. As the opioid crisis has escalated, so too, have prices for variations of naloxone” (p. 17). Dr. Joseph Ross of Yale University examined the price increases of naloxone and found that the drug company, Hospira, had increased the price of its injectable version of the drug from \$62.29 in 2012 to \$142.49 in 2016. Additionally, the drug company, Kaléo Pharma, raised the price of its auto injector version of the drug, Evzio, from \$690 in 2014 to \$4,500 in 2016 (Gupta, Shaw, & Ross, 2016). The price increase in the drug used to save people from taking drugs is ironic and alarming. Nevertheless, this is a factor in the overall costs associated with fighting the opioid epidemic.

New Jersey’s GSL (NJOPA). The definition of “Good Samaritan” laws varies by state, but it is generally defined as a law that protects a person or persons from prosecution of criminal offenses for helping someone, including themselves, who needs medical assistance. In the State of New Jersey, the official name of its GSL is called the “New Jersey Overdose Prevention Act.” Governor Chris Christie signed the NJOPA into law in 2013 and it clearly states that the overarching purpose of the statute is to “encourage persons to seek immediate medical assistance whenever a drug overdose occurs” (Hoffman, 2013, p. 2).

The NJOPA received bipartisan support and was sponsored by State Senators Joseph F. Vitale, Loretta Weiberg, and Richard Codey (S.B. 2082, 215th Leg., Reg. Sess. (N.J. 2012). The NJOPA currently aims at fighting the opioid epidemic in two ways: (1) granting immunity from some drug charges to individuals who seek emergency assistance for someone experiencing an overdose and (2) access to the drug naloxone and immunity to the first-responders who administer it (Hoffman, 2013).

People are generally hesitant to call the authorities for medical assistance due to fear of arrest and prosecution. This law addresses that concern and its purpose is to save lives by

Alleviating the fear of arrest and prosecution that might discourage or delay a call for help. To accomplish this vital goal, the new law provides legal protection in the form of immunity from arrest, prosecution, or conviction for a use of simple possession drug charge. (Hoffman, 2013, p. 2)

However, in order for these laws to achieve their goals, the police, prosecutors, and judges must know about its existence and how to apply it. Furthermore, and most importantly, the “victim” himself/herself or the person calling the police must know that the law exists, and they must have the trust and courage to actually make the call with the belief that they will not be prosecuted.

Keyword searches were completed in order to review additional texts and scholarly articles using major educational databases. The keywords used to determine the concepts about the effectiveness and implementation of GSLs were the following: opioid, overdose prevention, overdose prevention act, 911 calls, police.

Concepts of GSLs

In order to address the high death rates resulting from the opioid epidemic, 41 states, as of 2017, have implemented GSLs. However, in order for these laws to be effective, the public must know of the law’s existence so that it can be utilized effectively. In order to determine the decision-making factors that go into making the phone call, Latimore & Bergstein (2017) conducted 22 in-depth interviews with needle exchange program participants from Baltimore, MD. Results indicated that the majority of people called for help for a person who was experiencing an overdose. They did this because of a “moral or ethical imperative” to save a life. However, the fascinating thing is that the majority fled the scene prior to police arrival due to the fear of arrest and mistrust of police (Latimore & Bergstein, 2017, p. 84). They would often watch from around the corner or another place of cover. Because of a history of mistrust

between the police and community, callers cited fear of a drug charge, or even worse, a murder charge, as the main reason they do not remain on scene (Latimore & Bergstein, 2017). Many people felt that police would interrogate them and they were scared that they would get involved in something that could be a parole or probation violation. Moreover, people who did not stay on scene cited social fears such as losing their squatter's right to housing, family or friends finding out about where they were, or drug dealer retaliation (Latimore & Bergstein, 2017). The evidence in this study suggests that although states implement GSLs, the caller may still leave the scene and would call the police regardless of the GSL due to a personal moral obligation.

In New York, GSLs were also implemented in an attempt to decrease the amount of drug overdose deaths by eliminating fear of arrest by the caller and bystander. Out of 300 people interviewed in needle exchange programs and methadone treatment centers, 85% were unaware of the protections provided to witnesses and 83% were unaware of protections provided to the victim (Zadoretzky, McKnight, Bramson, DesJarlais, Phillips, Hammer, & Cala, 2017). Zadoretzky et al., (2017) reported that the main factors for lack of calling was a misunderstanding of the law and fear of arrest. Yet, 75% of people still reported calling the police, and 85% stated that they would call in the future. The participants studies by Bohnert, Nandi, Tracy, Cerda, Tardiff, Vlahov, & Galea (2011) essentially felt the same “moral and ethical imperative” (p. 84) as the participants in the study conducted by Latimore & Bergstein (2017).

Mistrust between the police and community appears to be a common reason for the continued fear of arrest that GSLs aim to eliminate. Using data from the Chief Medical Examiner of NYC, NYPD, and U.S. Census, Bohnert et al., (2011) examined the time-series data of 74 NYPD precincts over a 10-year period from 1990-1999. Misdemeanor arrest rate was the

independent variable and overdose rate was the dependent variable. It was concluded that levels of police activity in a precinct are associated with accidental drug mortality. Bohnert et al., (2011) believe this pattern holds true because of the belief that there is mistrust in the community towards the police due to more aggressive policing and arrests, which resulted in more people being scared to call the police on someone who is actively overdosing because of fear of getting arrested.

Conversely, a study by Time, Payne, & Gainey (2010), focused on attitudes of the public towards GSLs and Bad Samaritan Laws (BSLs), which are laws that can have repercussions for people who stand by and do not help a victim. Their research to investigate the increase in GSLs due to the drug epidemic and other social incidents sparked outrage in the news. Nevertheless, of the 134 “bystanders” surveyed, the majority stated that they would help someone in need, but there was mixed response about whether it should be required by law (Time et al., 2010). This study, although not related to the opioid epidemic directly, is important because it shows the start of a discussion about transitioning from the huge increase in GSLs to possibly forcing bystanders to call or else be charged in violation of BSLs.

Naloxone

As demonstrated above, the use of naloxone by first-responders is a way to combat the opioid epidemic and lower the number of deaths resulting from the same. It is an idea and action that requires funding from all levels of government and is to be implemented overwhelmingly by the local police agencies and local first-responders. DEA and FBI agents are not the ones that use naloxone on people, because they simply are not the ones responding to emergency overdose calls. Therefore, it is up to each state to develop its own law and/or policy concerning the use of naloxone by first-responders.

In this researcher's site location, located within a centralized county in New Jersey, the naloxone policy clearly states that its main purpose is for the utilization of opioid antidotes by law enforcement officers in an effort to "treat and reduce fatal opioid overdoses" (Maxwell, 2014, p. 1). In this regard, it states the same purpose as the NJOPA, which is to save lives during this opioid epidemic. This local department policy is based on the County Prosecutor's Office policy, which was created in response to the State of New Jersey's desire for all agencies to equip their officers with Narcan (naloxone). The State of New Jersey cannot force every agency to carry naloxone because it would have to fund the purchase of it. The NJOPA Directive states:

Every law enforcement agency operating under the authority of the laws of the State of New Jersey that equips its members with Narcan must develop and enforce policies and procedures to ensure that each deployment of Narcan is documented on a form and in a manner as may be prescribed by the Director of the Division of Criminal Justice. Completed Narcan deployment forms shall be collected by the Narcan coordinator for that agency, or, in the case of a municipal law enforcement department, by the county Narcan coordinator. (Hoffman, 2014, p. 4)

Furthermore, there is required countywide training that instructs police officers on how to use naloxone. This training consists of an explanation of the basics such as the nomenclature of the naloxone kit to the actual assembly and application of naloxone, which is administered intranasally to the drug overdose victim (Lavelle, 2014).

In New Jersey, the data collection on naloxone administration by first-responders (police officers, EMTs, paramedics) began in 2015. Since that date, naloxone administrations have increased every year from 7,227 (2015) to 10,308 (2016) to 14,356 (2017) to 16,082 (2018) (N.J.

DL&PS, 2020). The most recent year of 2018 shows one of the centralized counties of this study as one of the top five counties of naloxone administrations in the State of New Jersey. Three out of the other four counties with the most naloxone administration are located north and south of the site location of this study and were discussed in relation to their location near Philadelphia and New York City.

Keyword searches were completed in order to review additional texts and scholarly articles using major educational databases. The keywords used to determine the concepts about the effectiveness and implementation of naloxone use by first-responders were the following: naloxone, Narcan, overdose prevention, first-responders, police, heroin, opioid death prevention, and phenomenological study.

Concepts in Naloxone Use by First-Responders. Davis, Webb, & Burris (2013) conducted a study to show the possible benefits of naloxone use by first-responders. Drug overdose death is the leading cause of accidental injury death in the United States at this time and the use of naloxone can help prevent a lot of these deaths, when administered in a timely manner. However, Davis et al. (2013) argue that many of the laws in place at this time predate the opioid epidemic and that evidence suggests that amending or changing those laws to allow the use of naloxone by first-responders will support a decrease in the death rate. They further argue that in changing the law to allow the use of naloxone by first-responders, there are no negative benefits, and its use can be implemented at little or no cost (Davis et al, 2013). This finding, however, contradicts a later study by (Davis et al., 2014) that states more research is needed to determine the cost benefit analysis of naloxone used by first-responders.

One particular study by Rando, Broering, Olson, Marco, & Evans (2015) sought to answer the specific question: “Can police officers administer intranasal naloxone to drug

overdose victims to decrease the opioid overdose death rate?” Their interventional study was conducted in Lorain County, Ohio from January 2011 to October 2014. In October 2013, police officers were required to use naloxone on overdose victims. Using statistics from the County coroner’s office on 247 individuals, Rando et al., (2015) found that, “the number of opioid overdose deaths decreased each quarter with an overall average of 13.4 deaths. Of the 67 participants who received naloxone by police officers, 52 (77.6%) survived, and eight (11.9%) were lost to follow-up” (p. 1201). This is a clear and convincing study that supports the entire reason policymakers implemented the use of naloxone in the first place – to save lives.

A more recent publication by The American College of Emergency Physicians (ACEP), the National Association of EMS Physicians (NAEMSP), and the American College of Medical Toxicology (ACMT) states that almost all agree that victims of an opioid overdose should be treated and the use of naloxone should be allowed but not required for administration by public safety or health professionals, including but not limited to law enforcement officers, firefighters, emergency medical responders...(Annals Of Emergency Medicine [AOEM], 2017). They break down specific reasons as to why naloxone should or should not be used by all first-responders; one of the interesting points of emphasis is that if naloxone is readily available at an out-of-hospital setting, police and first-responders should not use the naloxone units provided to them because it is “clinically unwarranted and fiscally unwise” ([AOEM], 2017). Additionally, they support the use of naloxone, if and only if, everyone is trained properly on how to administer it and if there are resources and policies in place for that particular agency. This leads to the concept of public education about GSLs and naloxone.

In an attempt to involve key stakeholders at the local level, the federal government started a program called Enhanced State Opioid Overdose Surveillance (ESOOS). Since the

ESOOS program started in 2016, 32 states have received funding to be used to: 1. Increase the timeliness of reporting nonfatal opioid overdoses through emergency department and medical data; 2. Increase the timeliness and comprehensiveness of reporting fatal opioid overdoses; and 3. Disseminate surveillance findings to key stakeholders in order to inform prevention and response efforts for opioid overdoses ([CDC ESOOS], 2020). New Jersey is one of the states that received funding from this program. Although some of the data gained through this program can be analyzed and disseminated to stakeholders at the local level, there is still no such support from the federal government in regards to information obtained from the lived experience of the police officer on scene of a drug overdose.

Stakeholder Perspectives

Opioid overdoses usually happen in the presence of another person. Therefore, it would make sense to get the perspective from someone who has witnessed an overdose, and gauge exactly how he or she feels about GSLs and the use of naloxone. Richert (2015) conducted qualitative interviews with 35 people who had witnessed an overdose. He found that heroin users were typically concerned and wanted to get help for overdose victims. However, there are some factors, like being physically unable to get them help because of their own high, not wanting to disturb the victim's own high, difficulty assessing the situation, not knowing the victim's intentions, and fear of arrest from police involvement (Richert, 2015), that prevented them from doing so. As a result of the findings, it can be concluded that heroin users have a difficult time making decisions when witnessing an overdose. A possible solution is to train users on how to use intranasal naloxone and educate them about the immunity from arrest when calling 911 (Richert, 2015). Although this study was conducted in Sweden, it can be assumed

that the attitudes of drug users are universal, and perhaps even more heightened in America, depending on the differences in criminal laws and social acceptance.

In New Jersey, specifically within the three counties for this site study, police officers are usually the first to respond on scene for an overdose, due to the majority of EMT's being volunteers. They generally beat the EMT's and paramedics to the scene and are the ones administering naloxone. Moreover, there is a good chance that they know the victims on a more personal level because of possible prior arrests, previous overdoses, or simple police interactions. Police officers utilize a person's publicly recorded information as well as their comprehensive criminal history (CCH) often when they come in contact with someone for a legitimate reason. Therefore, it is imperative to take seriously the perspectives of law enforcement and include their experiences when deciding how to combat the opioid crises. Unfortunately, little data exists on law enforcement attitudes toward overdose prevention and response (Green, Zaller, Palacios, Bowman, Ray, Heimer, & Case, 2013). However, they conducted a study with interviews of 13 police officers over three different locations in Rhode Island and Connecticut to determine attitudes towards and beliefs about overdose prevention and naloxone. Overall, law enforcement attitudes were positive with police, of wanting to help the victim and this crisis. However, there was much frustration with the revolving cycle of an addict, lack of options for treatment for the overdose victim, lack of local treatment centers, and the ease of access to prescription opioids (Green et al., 2013).

A study across the country in the State of Washington was also conducted in 2013 regarding the experiences of police officers and paramedics after the recent implementation of GSLs and take-home naloxone. Seventy-five percent of officers (n=251) felt that it was important that they were at the scene of an overdose to protect medical personnel and 34% felt

that it was important to be there to enforce the laws (Banta-Green, Beletsky, Schoeppe, Coffin, Kuszler, 2013). Additionally, some of the police officers in Washington, ranging from 10-50%, did not know about the existence of GSLs or did not know how to correctly apply the law across different situations (Banta-Green et al., 2013).

Work programs established in this country are intended to help unemployment rates, reduce poverty, and control social order. There is a strong correlation between unemployment and crime. Therefore, it would be reasonable to consider developing work programs for overdose victims or people addicted to drugs who commit crimes to get money to see if it would reduce crime and/or drug use among them. Work programs are another “outside of the box” idea, in addition to the GSLs and naloxone laws, that may help the overdose victim. In a mixed-methods study, Uggen & Shannon (2014) spoke with addicts leaving drug treatment centers and discovered that employment does not change cocaine or heroin use. However, there was clear evidence that employment reduced predatory economic crime, which is consistent with criminological theory. Burglary and robbery arrests fell by 46% of those employed compared to the control group (Uggen & Shannon, 2014). This is most relevant from the perspective of the three stakeholders that appear to be forgotten – police, taxpayers, and local communities. This study suggests that people addicted to drugs commit crimes to get the money to obtain drugs, but also that employment alone will not stop the use of drugs and overdoses.

Conclusion

The opioid epidemic is explained and defined by the CDC as the steady and alarming increase of over quarter million deaths, specifically from opioids over the last 15 years (CDC, 2018). Local solutions by state governments to combat the epidemic include using more money for various reasons and implementing new laws and policies like GSLs and naloxone use by

first-responders. These new laws were researched by different professionals in the healthcare and medical community, prior to their passing to achieve the goal of saving lives. However, nearly 10 years after the implementation of these laws, death rates are still on the rise.

Approaching this problem through the eyes of a moral hazard perspective, this outcome makes sense because the drug user, having little fear of arrest and no fear of dying, takes on higher risk behavior. The time is now to consider if GSLs and naloxone policies are having unintended consequences for the community.

While there is sparse research on this topic, one of the rare articles that demonstrated the impact of GSLs and naloxone use from an economic and crime perspective states that, “laws expanding access to the overdose-rescue drug, naloxone, have resulted in greater opioid abuse and opioid-related crime, has produced incendiary reactions in the addiction research community” (Knopf, 2018). The overall goal of saving a person’s life by enacting these two laws can be measured after their implementation. But the research on the unintended consequences from an economic and crime perspective is very limited and lacks depth from a law enforcement perspective. Moreover, since the drug epidemic is a hot topic in society today, the mere suggestion of alternate approaches of addressing the use of naloxone can cause a sense of uneasiness among researchers and perhaps, cause them to shy away from conducting research at this time. This should not be the case, as more research is needed on this topic to truly help society as a whole. A phenomenological study of the lived experiences of the first-responders affected by GSLs and naloxone policies could identify common themes and contribute to the knowledge about whether these laws and policies lead to positive outcomes.

CHAPTER 3

METHODOLOGY

Due to the Coronavirus (COVID-19) Pandemic ([CDC], 2020) and a lack of response from participants in one out of the three centralized counties within New Jersey, certain research methods were changed from the original research intentions. After receiving initial permission from the site director of the paramedics that this researcher wanted to interview, access and availability was not granted, and thus, this research only included the experiences of police officers. The following sections will describe what was initially proposed and what actually happened as a result of the COVID-19 Pandemic. Documents such as the “Participant Recruitment Announcement” (Appendix C) and “Informed Consent” (Appendix F) were created and disseminated prior to changes, and thus, still use some language such as “paramedic” or “three counties” within the document.

The “war on drugs” in the United States continues to exist, but the tactics to combat the problem of drug use have changed ([CDP], 2015; [CDP], 2016; Davis et al., 2013). Even the phrase “war on drugs” was replaced with the phrase “opioid epidemic” in 2010 (CDC, 2018). According to the Center for Disease Control and Prevention (2019), more than 700,000 people died from a drug overdose from 1999-2017. More than 350,000 of these deaths were related to either an illicit or legally prescribed opioid (Seth et al., 2018; [CDC], 2019). As the prevalence of opioid use increased, specifically heroin, more and more deaths occurred. In 2016, the number of overdose deaths involving opioids, which included prescription opioids and heroin, was five times higher than it was in 1999. On average, 115 Americans die every day from an opioid overdose (Rudd et. al., 2016). As a result, policymakers and politicians across the country shifted from a hardline punitive approach to a rehabilitative approach in an attempt to save lives.

In response to the increase in opioid related deaths, policymakers at the state level started to implement the use of naloxone by first-responders, which includes police officers, as a way to save lives and lower the death totals beginning as early as 2010. The Office of National Drug Control Policy has stated that naloxone “should be in the patrol cars of every law enforcement professional across the nation” (TWH, 2013, para. 4). Massachusetts was one of the first states to run a pilot program using naloxone in 2010 in Quincy, MA. The Massachusetts Department of Public Health (MDPH) trained and equipped its police officers with naloxone (Davis et al., 2014). By 2013, at least five Good Samaritan Laws (GSLs) were also implemented, in hopes of eliminating the fear of arrest when calling the police for life saving medical care (Hoffman, 2013).

In New Jersey, the “New Jersey Overdose Prevention Act” (NJOPA) was signed into law by former Governor Chris Christie in 2013. This law provides immunity from prosecution of any kind (indictable offense, disorderly person offense, local ordinance) when a person is found in possession of or being under the influence of a Controlled Dangerous Substance (CDS) when the police are called to an overdose scene. There was an amendment to this law in 2015, which protected first-responders from being held liable when administering naloxone, also known as Narcan, to drug overdose victims (Davis, 2015). Police officers and paramedics had to change certain workplace procedures from the initial implementation of the NJOPA, like overdose scene investigations and arrest procedures (or lack thereof), to the more recent amendment of the NJOPA, like training and administration of naloxone.

The number of overdose deaths and naloxone administrations can be quantified and broken down by city, county, and state (New Jersey Division of Law & Public Safety [N.J. DL&PS], 2019). However, qualitative inquiry about the lived experience of first-responders

since the passing of the NJOPA and use of naloxone in New Jersey was not found. Therefore, the purpose of this transcendental phenomenological study is to explore how police officers and paramedics within three centralized New Jersey counties have lived through the phenomena of providing medical care to overdose victims since the passing of the NJOPA. This research study contributes to the overarching research regarding GSLs and the opioid epidemic, as well as influences policymakers' decision-making concerning the implementation and amendments to GSLs and the use of naloxone by police officers and possibly other first-responders.

Research Questions

The following research questions guided the study:

RQ1: Are there common lived experiences of police officers and paramedics who have responded to a drug overdose call since the passing of the New Jersey Overdose Prevention Act?

RQ2: How do police officers and paramedics describe the changes in their workplace/procedures following the implementation of the New Jersey Overdose Prevention Act?

Transcendental science is rooted in psychology, but emerged from discontent by some of the existing science that only studied material things. Phenomenology is a way to take into account the lived experiences of a person and make the connections between human consciousness and objects that exist in the material world (Moustakas, 1994). When examining the NJOPA, data can be obtained in regards to material objects such as the number of drug overdose deaths, the types of drug paraphernalia on scene, the amount of drugs on scene, and the location of the overdose. In order to understand a phenomenon from the point of view of the police and paramedics who have been affected by the NJOPA, a qualitative, transcendental

phenomenological study is appropriate. Van Kaam (1969) noted that relevant research is that which “explores, describes, and empirically tests human behavior while preserving a “lived” relationship with it in the reality of life” (p. 26-27). The following section describes the research design and how it was used to seek the answers to the research questions.

Research Design

This phenomenological study sought to examine the unique experiences that police and paramedics have when responding to drug overdose calls and working with drug overdose victims. However, due to the COVID-19 Pandemic and the loss of site-director permission for the paramedics to participate, only police officers’ experiences were captured. A phenomenological approach is well suited to studying emotional and intense human experiences (Merriam, 2009). It is understood that saving another human being’s life can be classified as an intense human experience, and therefore, this research study is designed in an attempt to capture that emotion. A police officer’s or paramedic’s emotional response from this experience can be captured and coded to provide important themes and viewpoints from the perspective of these significant stakeholders. Policymakers that created the NJOPA have a different experience than that of the first-responders who respond to these emergency calls. The goal is to contribute findings about perceptions of their experiences to the academic community that can be used in the policymaking process.

Schram (2003), as cited in Merriam (2009), describes phenomenology as a study of people’s conscious experience of their life-world, which is, their “everyday life and social action” (p. 25). Phenomenologists focus on describing what all participants have in common and reduce individual experiences with a phenomenon to a description of the universal essence (Van Manen, 1990). Phenomenology does not endeavor to develop a theory to explain the world,

but instead looks to maintain greater contact with the world (Bloomberg & Volpe, 2015).

Transcendental phenomenology was used in this research design in order to avoid interpretations of experiences by the researcher. This is an appropriate approach, considering that this researcher is a police officer and has personal opinions and biases based on his own experiences of responding to drug overdose calls.

Transcendental phenomenology consists of three core processes that aid in the derivation of knowledge: Epoche, Transcendental-Phenomenological Reduction, and Imaginative Variation (Moustakas, 1994). Epoche is essentially the idea that the researcher will refrain from judgments based on their everyday understandings of this phenomenon, and take a fresh, naïve approach to the topic (Moustakas, 1994). This stance is necessary in this study because of the researcher's full-time career as a police officer and experiences dealing with overdose victims and the NJOPA. This researcher kept a reflection journal to aid in the reduction of his preconceived judgments.

The next step is Transcendental-Phenomenological Reduction. This means that each experience is considered in its singularity, in and for itself. It is described using variations of perceptions, thoughts, feelings, sounds, colors, and shapes by the participant (Moustakas, 1994). From these statements, a textual description of the meanings and phenomenon can be captured, and were used to help uncover common themes of the phenomenon.

The final step is Imaginative Variation. Its aim is to "grasp the structural essence of experience" (Moustakas, 1994, p. 35). It is in this step that a structural description of the participant's experience is formed and a picture is presented that connects the conditions that "precipitate an experience" (Moustakas, 1994, p. 35). In other words, Imaginative Variation involves "viewing the data from various perspectives, as if one were walking around a modern

sculpture, seeing different things from different angles” (Merriam, 2009, p. 26). Imaginative Variation helps the reader experience what the police officers and paramedics experience from an additional structural description, which in turn, is their reality.

The nature of a phenomenological study is to capture a common, shared, lived experience through participants who experience a phenomenon. In this case, the experience is being a police officer or paramedic in New Jersey, and the phenomenon is responding to a drug overdose after the passing of the NJOPA. Therefore, all participants in this study are police officers in New Jersey, and had at least one experience saving or trying to save an overdose victim’s life. These participant selection criteria reflect the research questions that framed this study.

Setting

A description of the setting should incorporate all important aspects of the environment, history, background, and culture. Identifying what is unique about the setting helps to place the study within a context (Bloomberg & Volpe, 2015). The setting for this study was the State of New Jersey. Although the opioid epidemic, GSLs, and the use of naloxone is almost a nationwide phenomenon, the NJOPA and the actions that police and paramedics take as a result, are what fueled the research questions for this project.

New Jersey is located in the northeastern United States, and sits between two major cities--Philadelphia, Pennsylvania and New York City, New York. It is also relatively close to where the first pilot program of naloxone was used by police officers in Massachusetts in 2010. According to the U.S. Census Bureau, the estimated population in New Jersey in 2018 was 8,908,520 (2019). Based on the latest 2010 census report, the population per square mile is 1,195.5, making New Jersey the most densely populated state. It is also one of the most ethnically diverse states in the country. Minority population (persons other than non-Hispanic

whites) increased to 45.1% in 2018 compared to 40.4% in 2010 (New Jersey Department of Labor & Workforce Development [N.J. DL&WD], 2019). Furthermore, there were three intended centralized counties for this study within the State of New Jersey that were identified for the study and where the participants' experiences took place. These counties were chosen based on where the researcher works and to whom he has access to as participants. However, only participants from two of the three centralized counties intended to be studied responded. New Jersey, being geographically located in the northeast region of the country and having a central location between two major cities –New York City and Philadelphia - add to the unique experience of a police officer and paramedic. It is understood that the two New Jersey counties that served as the setting for this type of study cannot be generalized to other counties within the State or other states throughout the country.

In this setting, it is important to note that the majority of fire departments in the State of New Jersey are volunteer and unpaid. About 75% of all fire departments in New Jersey were staffed with volunteers in 2012 (Mikle, 2014). Therefore, the primary first-responders on scene for an overdose are the police and paramedics. Firefighters and paid rescue squads, who are often certified EMT's and respond to drug overdose calls in many states, are not as prevalent in New Jersey, and therefore, not as likely to respond to or be the first on scene for a drug overdose. By only focusing on a police officer's experiences, (as paramedics were unavailable for the planned study) greater specificity regarding drug overdose experiences was provided (Volunteer rescue squad members or firefighters who later arrive on scene, and who only aid the primary first-responders will be excluded). Semi-structured interviews with participants were to be conducted through either a conference call or in person interview. However, due to the COVID-19 Pandemic, only online web-based interviews were conducted. All participants had the

common experience of working as a police officer in New Jersey and responded to at least one overdose call since the passing of the NJOPA.

Participants and Sample

Study participants were selected using a non-random, purposive sampling method, and all participants were to be a police officer in New Jersey who have responded to a drug overdose call since the passing of the NJOPA. Purposeful sampling is used in qualitative research; researchers intentionally select individuals and sites to learn about or understand a central phenomenon (Creswell, 2015). Patton (2002), as cited in Creswell (2015), states that the standard in purposive sampling in choosing the participant and site is that they are information rich. Two centralized counties within the State of New Jersey were the location of the study, and police officers acted as information-rich participants. Purposeful sampling is used when the researcher wants to gain insight to a phenomenon and it provides the best chance for the most to be learned (Merriam, 2009).

Stratified sampling was to be used to achieve a balance between the number of police officers and paramedics. Stratified sampling is when the researcher divides the population on some specific characteristic (in this case police officer or paramedic) and then, using simple random sampling, chooses a sample from each subgroup (Creswell, 2015). This strategy was intended to increase the odds that the participants were to be half police officers and half paramedics, but was not needed since there were no paramedics sampled due to the COVID-19 Pandemic.

Finally, snowball sampling was used as an option to get 10 total participants and achieve the initial goal of 8-12 participants. Snowball, chain, or network sampling, is actually a common form of purposive sampling, and this researcher used it as a tool when participant response was

short of the sought after minimum. Snowball sampling typically proceeds after a study begins and occurs when the researcher asks a participant to recommend another participant that has the same criteria for inclusion (Creswell, 2015; Merriam, 2009).

Each police department in the study site counties is under the control of their respective Chief of Police (site director). This researcher's Chief of Police sent an email or called on the phone to each town's Chief of Police and requested permission for this researcher to conduct this study. Once permission was granted, each site director, or Chief of Police, sent out the recruitment announcement (Appendix C) through their chain of command to all of the police officers in their agency. Some Chiefs of Police gave permission, but preferred that the notice was sent out the recruitment announcement directly. The recruitment announcement instructed to have any willing participant contact the researcher directly. Verification that the participant was a police officer was done by either looking at their government issued police identification, confirming their work phone number or email (usually ending @policedepartment.com), or looking up their name in online public records for the police pension system.

In order to retrieve the names of paramedic participants, an email was to be sent to each paramedic within the Health network within the tri-county area. The Clinical Manager of the Mobile Health Unit, who is in charge of all paramedics in the central New Jersey region, was to send the email. However, due to the COVID-19 Pandemic, this did not occur.

A phenomenological study is about capturing the richness of a participant's experience. There is no set number of participants for this type of study; however, the goal of 8-14 participants was set and reasonable considering the designated time frame for this project and the likelihood of saturation. Each participant met the following selection criteria:

1. Police officer (paramedics were not recruited)
2. Works within one of the three centralized counties in the State of New Jersey
3. Has responded to a drug overdose call and administered naloxone, and
4. The call has occurred since the implementation of the NJOPA in 2013

Seven police officers responded directly to the recruitment announcement. Snowball sampling was done to recruit three more participants. During this recruiting process, this researcher attempted to get a diverse sample of participants based on their gender, profession, and geographical location/agency. Gender diversity was not achieved as all participants were male, and professional diversity was not needed because paramedics were no longer recruited. Various geographical locations were represented as a direct result of having agency diversification and various police departments represented from within each county.

Participant Rights

As part of the requirements of the University of New England (UNE), this researcher completed the CITI Online Training on Human Subjects Protection (See Appendix E). This researcher also received approval from the UNE Institutional Review Board (IRB) (See Appendix G). All participation was voluntary and those who participated were provided an informed consent form (See Appendix F). This form included the purpose of the study, the duration of the interview, the participant's right to stop at any time or refuse to answer any question, an overview of the data collection process, and how the participant's confidentiality will be maintained. Support services were recommended or provided to any participant who requested them or showed signs of emotion triggered by sensitive questions. Once an individual showed interest in participation and this researcher verified his identify and that they met the criteria, this researcher communicated with the participant via his personal email and cell phone,

and not a work email or phone number. Any research done on a public line or email was avoided. All relevant materials collected from participants will be destroyed in three years.

Instrumentation and Data Collection

The instrument in qualitative research is the researcher and the interview itself, as opposed to quantitative research that uses someone else's instrument (Creswell, 2015). The collection of data from the 10 participants came from the responses from a semi-structured interview with police officers on their perceptions and experiences while responding to a drug overdose call in New Jersey since the passing of the NJOPA. Each interview was approximately 30-45 minutes in length. However, because they were phenomenological interviews, participants did not have to answer the exact same questions. Therefore, a semi-structured format was followed (Moustakas, 1994). As a result, completion time varied.

Piloting the interview. A pilot test was conducted with this researcher's Chief of Police and the site director for the paramedics. A pilot test of an interview survey is a procedure in which the researcher makes changes in the instrument (interview questions) based on the feedback from a small number of people who complete and evaluate the instrument (Creswell, 2015). This researcher received feedback from the professionals who completed and evaluated the instrument, and made any changes to the concerns they presented. They were not included in the final sample of the study. Moreover, although the paramedic supervisor completed the pilot interview and ultimately could not be reached again for recruitment announcement dissemination, his suggestions were still noted.

Semi-structured interview protocol. The interviews were conducted via the Internet using Zoom.com, which provides video and audio conferencing. This technology also allowed the interview to be recorded and stored directly onto the hard drive. Standard questions were

part of the format with the ability of the participant to expand on each question, or for this researcher to ask a follow up to expand or clarify a question (See Appendix D).

Data Analysis

A phenomenological study aims at understanding the experiences of individuals who have lived through a certain phenomenon. In this case, the experiences of police officers were captured, and therefore, this study did not try to prove, measure, or discover specific types of data (Moustakas, 1994). In order to analyze this data while recognizing potential bias, this researcher engaged in the first step mentioned earlier in Transcendental Phenomenology, known as Epoche.

Police officers have strong personality traits (Evans, Coman, & Stanley, 1992) and a majority of their job is to look for patterns, profile people and situations, and make determinations based on evidence, statements, and probable cause. Based on this researcher's everyday experiences as a police officer, the researcher was prone to bias going into each interview. In order to combat this, the researcher utilized the process of bracketing, by keeping a journal or drafting analytic memos, of his thoughts about the NJOPA and his personal experiences. Before each interview, this researcher reminded himself of the purpose of the study and strived to not let his personal feelings dictate the questions or the way that he asked the questions. The goal was to be as naïve as possible (Moustakas, 1994).

The interviews were transcribed by the professional transcription service, Rev.com. Participants were allowed to check their responses and an email was sent to them to review the accuracy of their statements and make sure that everything that they wanted to say was captured. This process is known as member checking. Descriptive coding was done to capture common ideas and themes that the participants shared.

Limitations of the Research Design

This study addressed the phenomenon of the lived experiences of police officers who responded to a drug overdose call after the passing of the NJOPA. Other research has indicated a need to align policy aims with lived experiences of overdose bystanders to achieve overdose prevention aims (Latimore & Bergstein, 2017). Moustakas (1994) states that there should be a dynamic interchange between the researcher and participant in order to pull out the complete lived experience.

As a police officer and researcher, this researcher is prone to bias from that perspective. This may create a prejudice that may have been exposed during the interview with the participant. Although the questions were put through a pilot test with this researcher's Chief of Police and a Paramedic Supervisor, it was imperative that the tone or way in which the questions were posed remained steady and with the same type of emotion expressed for the follow up questions for all. The removal of personal views may be difficult to achieve (Moustakas, 1994). However, it is not until personal belief is suspended that consciousness itself becomes heightened and can be examined in the same way that an object of consciousness can be examined (Merriam, 2009). In order to become aware of personal experiences, this researcher used the process called *Epoche*, where judgments and knowing are set aside (Moustakas, 1994). However, the degree to which a person can bracket his or her own assumptions is up for debate (Merriam, 2009).

Trustworthiness and Credibility

As with any qualitative or phenomenological research, this study cannot be used to generalize for the larger population (Bloomberg & Volpe, 2012) of police who responded to a drug overdose since the passing of the NJOPA. Referencing Smith et al. (2009), and van Manen

(1990), Bloomberg & Volpe (2012) state that “phenomenology does not endeavor to develop a theory to explain to the world; rather, the aim is to facilitate deeper insight to help us maintain greater contact within the world” (p. 48). This study adds additional insights from the perspective of police officers’ lived experiences and contributes to the decision making by New Jersey policymakers and other federal and state policymakers.

Additionally, this researcher sought to complete a study that is trustworthy, dependable, and credible. Unlike a quantitative study, validation is not sought in a qualitative study, and the trustworthiness of this study was captured by making sure that the participant’s perceptions matched up with the researcher’s portrayal of them (Bloomberg & Volpe, 2015). Textual and structural descriptions from the interviews were provided to participants for them to confirm or deny that their message was perceived and shared correctly. This added to the credibility (Moustakas, 1994).

Although this study cannot be generalized to a larger population, it can still be useful and applied to other counties within the state or country that share a similar setting. “Transferability refers to the fit or match between the research context and the context as judged by the reader” (Bloomberg & Volpe, 2015, p. 164). The first factor of detailed information concerning the background/context of the topic and the second factor of thick and rich descriptions included in the study offer an element of shared experience and an overall increased level of trustworthiness (Bloomberg & Volpe, 2015). It is up to the investigator to provide enough descriptive data to make transferability possible (Merriam, 2009). This researcher provided that descriptive data. The two counties that served as the study site have a combined total of over 1 million residents, an area over 600 square miles, and an average household income of over \$65,000. The participants are sworn, full-time police officers certified by the New Jersey Police Training

Commission (PTC). This information makes this study transferable, which adds to the trustworthiness of it.

Conflict of Interest

This researcher is currently a police officer in a centralized, mid-sized police department in the State of New Jersey. In order to decrease any conflict of interest, the scope of research participants disqualified included other police officers from the same police agency. This eliminated the possibility of having a participant who worked with this researcher, who was influenced by this researcher, or who has influenced this researcher, in regards to the training, emotions, and lived experiences, or who responded to drug overdose calls. By limiting the number of police officer participants to only those who work outside this researcher's agency, the possibility of a conflict of interest was limited. Paramedics from any hospital were to be included, but no paramedics participated in this study.

Ethical Issues

Respect for audiences and the use of nondiscriminatory language are ethical concerns that should be addressed in research (Creswell, 2015). The participants who were police officers were treated with the same protections as the drug overdose victims in this study. This is especially important in working with participants who work for a public agency and take an oath to do their job. The integrity and credibility of this project are important to contribute something significant to the research community. Their candid responses were those of their personal opinions, and there was no evidence to suggest that their professional duties were compromised. Therefore, it was important to weigh the benefits of this research with the risks. Any answers that were deemed discriminatory could have jeopardized public trust. This reality was made known on the informed consent form, and no one was pressured into signing or participating in

this study. However, no responses were edited or changed, thus ensuring the integrity of this study.

To further expand on this topic, if certain responses rose to the level of criminal negligence or some other response that could be incriminating, this researcher would have reported the action to a higher authority. Each participant's confidentiality was protected to the extent permitted by law. This researcher did not encounter any criminal activity by any participants. Each participant was made aware of his protections via the consent letter in Appendix F.

A final ethical issue that was presented to this researcher was that of personal opinion towards the participants after the research was completed. Although the results are confidential to the public, this researcher still knows the participants' responses since he is the person who interviewed them and coded their transcript. Fellow police officers from this researcher's agency were disqualified from this study, but there is the possibility that this researcher could respond to a call or work with another police officer from another agency in some capacity. This researcher's personal opinion and biases developed towards colleagues as a result of this study, could have an effect, either positive or negative, on the way that this researcher treats them, interacts with them, and/or views them or their agency.

Conclusion

The "war on drugs" continues to exist and the tactics to approach the "opioid epidemic" have shifted from previous years ([CDP], 2015; [CDP], 2016; Davis, Webb, & Burris, 2013). In 2016, the number of overdose deaths involving opioids, which included prescription opioids and heroin, was five times higher than it was in 1999. On average, 115 Americans die every day from an opioid overdose (Rudd et al., 2016). As a result, policymakers and politicians across the

country shifted from a hardline punitive approach to a rehabilitative approach in an attempt to save lives. GSLs, like the NJOPA, have changed the way police and paramedics respond to and handle drug overdose calls. However, research on the lived experiences of those involved is needed to make sure policy aims are met (Latimore, & Bergstein, 2017). Therefore, the methodology of this qualitative study was transcendental phenomenology. This method was used to capture the lived experiences of these participants who are professional first responders affected by the NJOPA.

The above listed research questions were sought to be answered in this research design. In order to derive this knowledge, the three core processes in transcendental phenomenology were attempted: Epoche, Transcendental-Phenomenological Reduction, and Imaginative Variation. A non-random, purposive sampling method, using snowball sampling methods, was completed in the setting of where the NJOPA exists. Participant rights, researcher bias, conflict of interest, ethical issues, and limitations of this study were all addressed. The following chapter will present the results generated from this research study and explain how they were achieved, followed by implications and recommendations from this researcher.

CHAPTER 4

RESULTS

According to the Center for Disease Control and Prevention (2019), more than 700,000 people died from a drug overdose between 1999-2017. More than 350,000 of these deaths were related to either an illicit or legally prescribed opioids (Seth, Scholl, Rudd, & Bacon, 2018; Center Disease Control [CDC], 2019). The opioid epidemic can be explained through outlining the three waves of the rise in opioid overdose deaths: Wave 1: Prescription opioid overdose deaths; Wave 2: Heroin overdose deaths; and Wave 3: Synthetic opioid overdose deaths ([CDC], 2019) (See Appendix A). As a result of this national epidemic, but because it was experienced differently within each State, the responses to the epidemic varied widely. In 2013, New Jersey Governor Chris Christie signed into law the New Jersey Overdose Prevention Act (NJOPA) as one way to combat the opioid epidemic. One widely used and highly impactful action supported by the NJOPA was the common use of naloxone by police officers. While this implementation came after the promulgation of the NJOPA, and while it is not a law that police officers be mandated to administer naloxone, it has been the practice of law enforcement.

As with all practices, the NJOPA and use of naloxone by police officers should be examined to determine if it is effective and/or if there are unintended consequences or problems that can be presented for examination to policymakers or chiefs of police. Because of the limited literature on the lived experiences of police officers who are affected by the NJOPA and who administer naloxone on a drug overdose call, this transcendental phenomenological study explored how police officers in two centralized counties within New Jersey perceived their experiences with responding to a drug overdose call after the signing of the NJOPA and the use of naloxone on a drug overdose victim. The following research questions guided this study:

1. Are there common lived experiences of police officers who have responded to a drug overdose call since the passing of the NJOPA?
2. How do police officers describe the changes in their workplace/procedures following the implementation of the NJOPA?

This chapter is organized into three parts. First is an overview of the data collection and analysis. Contained within the data collection discussion is how the data procurement and analysis was modified from the original plan as a result of the Coronavirus (COVID-19) Pandemic. Second, the demographics of the participants are presented and organized in a table. A brief narrative of each participant helped the researcher gain a better understanding of his experience. The third part of this chapter explores themes and subthemes that emerged from the data analysis of each participant's responses to the semi-structured interview.

Part One: Data Collection and Analysis

Data collection began after permission was obtained from the University of New England's Institutional Review Board (IRB) (See Appendix G) and the approval of the researcher's Chief of Police (site director). Additionally, because participants were to come from other public safety agencies neighboring the county where this researcher was employed, an email from this researcher's Chief of Police was sent to every other police department's Chief of Police (site directors) containing the Participant Recruitment Announcement (See Appendix C). This information was then disseminated to all police officers within their respective agency. This announcement contained the requirements for inclusion in the study and the contact information so that police officers who wished to participate could communicate directly with the researcher. If a chief of police gave permission for the research, but did not want to send out

the Participant Recruitment Announcement through their email directly, this researcher sent out the information to the police officers.

Initially, three centralized counties within the State of New Jersey were to serve as the location of this study for participants that were either a police officer or paramedic. Due to the COVID-19 Pandemic, this researcher did not receive approval from the site director in charge of all paramedics covering these three centralized counties. As a result, paramedics were not recruited and did not participate in the study. This eliminated the need for stratification sampling that was initially to be used to maintain participant balance between police officers and paramedics. Furthermore, although three centralized counties were targeted for police officers to participate, this researcher did not receive any responses from any police officers within one of the counties. Therefore, this study is limited to only police officers in two centralized counties within the State of New Jersey. Purposeful sampling was used and seven police officers responded directly to the researcher's participant request email. Snowball sampling was also used and resulted in three additional police officers participating in this study, for a total of 10, to achieve the goal of 8-14 participants.

In-person and/or online interviews were initially to be conducted based on the participant's desire and availability. During the time of this research, the world was experiencing the COVID-19 Pandemic ([CDC], 2020). This is important to note because it changed the way in which society operated, from communications to interactions and it impacted almost all aspects of life as citizens were asked to remain at home as much as possible and to limit interactions with others. As a result, there were some changes in the research methodology initially proposed in Chapter 3. As a result of the COVID-19 Pandemic, all 10 interviews were conducted online via Zoom.com, so that state and federal "social distancing" guidelines were

followed. The semi-structured interview questions (See Appendix D) were utilized and follow-up questions consistent with phenomenological interviews were posed (Merriam, 2009, Moustakas, 1994).

The first part of the interview consisted of gathering demographic and descriptive information. The second part of the interview consisted of open-ended questions in which the participant described their experiences with responding to a drug overdose call and administering naloxone on a drug overdose victim since the passing of the NJOPA. Interviews were audio and video recorded by Zoom.com and saved only on the investigator's hard drive. Copies were also saved on a USB drive as backup. The recordings were then transcribed by the technology platform, Rev.com, and copies of the transcripts were saved only on the investigator's hard drive and USB drive. All other copies were deleted. All relevant materials will be destroyed after three years. The researcher reviewed the transcripts and sent a copy to participants via email to "member check" and confirm that the data was accurate and that their responses and emotions were captured (Creswell, 2015). Nine participants verified that the transcripts were correct and one participant returned the transcript for a minor edit. The researcher assigned codes, PO1-PO10, to participants to protect their privacy.

Data analysis followed Moustakas (1994) three-step process: Epoche, Transcendental Phenomenological Reduction, and Imaginative Variation. In order to capture each of the participants' experiences, these steps aided in limiting the researcher's personal experience and bias. Coding was completed by the researcher and organized into a table on Microsoft Word. Data was organized based on significant statements by each participant (Creswell, 2015) that answered the same common questions to all participants and immaterial and repetitive statements

were discarded (Moustakas, 1994). Key words and phrases were then used to narrow down themes--and subsequent subthemes--that emerged.

Part Two: Demographics of Participants

A total of 10 police officers participated in this study. All of the participants were male. The age range of participants was from 26 to 43 years old, with the average age of the participant being 33.2 years old. All 10 participants held a Bachelor's degree with nine of them holding a Bachelor of Arts degree and one of them a Bachelor of Science degree. The number of years employed as a police officer ranged from three years to 15 years, with the average number of years as a police officer being 8.9 years of service. It was discovered that three of the participants had experience as an EMT/first-responder prior to being employed as a police officer. This information was noted, but not counted, as their years of service as a police officer.

The number of drug overdose calls that a participant responded to varied. Some participants were able to look up their call history and provide an exact number of calls, and other participants provided an estimated range of drug overdose calls they had responded to. The minimum number of responses to a drug overdose call for one officer was six, while the highest number of drug overdose calls responded to by one participant was over 100. This participant also worked in another southern county within the State of New Jersey prior to being employed in his current centralized county that is accepted as part of the centralized location in this study. This information was documented, and the majority of his responses were based on the experience working in his current centralized county location, to where his data reported in this study is restricted.

Over 20 different police agencies are located in each of the two centralized counties for this study. For purposes of this study, the participant's specific agency was noted, but it was

only listed as either C1 (County 1) or C2 (County 2) as part of the demographic data. Of the 10 participants, six worked in C1 and four worked in C2. Table 1 displays the participant demographic data described above.

Table 1

Participant Demographic Data

Name	Age	Sex	Highest Level of Education	NJ County Where Employed	Number of Years as Police Officer	Number of Responded to Drug Overdose Calls
PO1	34	Male	Bachelor of Arts	C1	11	10
PO2	36	Male	Bachelor of Arts	C1	10	6
PO3	38	Male	Bachelor of Arts	C1	14	10-20
PO4	28	Male	Bachelor of Science	C2	5	13-15
PO5	26	Male	Bachelor of Arts	C2	3	40
PO6	29	Male	Bachelor of Arts	C1	6*	>20
PO7	33	Male	Bachelor of Arts	C1	12	10-15
PO8	32	Male	Bachelor of Arts	C1	5	30
PO9	43	Male	Bachelor of Arts	C2	15*	25-30
PO10	33	Male	Bachelor of Arts	C2**	8*	>100

Note: C1 = Centralized County in New Jersey

C2 = Bordering Centralized County to C1 in New Jersey

*Indicates that this officer had additional time as an EMT/first-responder prior to becoming a police officer

**Indicates that this officer previously worked in a different southern NJ County

PO1

PO1 is a police officer who currently works for an agency within C1. PO1 had prior employment as a police officer for another police department that is located within C1.

Therefore, all of his answers and experiences were counted toward data analysis. PO1 holds a

Bachelor of Arts degree and has a total of 11 years of experience as a police officer and stated that he has responded to 10 overdose calls since the passing of the NJOPA.

PO1's knowledge about the NJOPA is that it is a law signed by Governor Christie that tried to take a proactive approach in response to the opioid epidemic by not charging drug overdose victims. He stated, "So from that point forward, any police officer was to treat a 911 overdose call as a medical first aid call and not a criminal investigation." PO1's knowledge about the use of naloxone is that it is "definitely effective at saving lives" and he has personally administered it three times to overdose victims. PO1 noted that it is important that police officers carry naloxone because, "you're there in a matter of less than a couple of minutes. Whereas an EMT, especially in the suburban area of New Jersey...might take them 10, 15, 20 or more minutes to get there."

PO1 stated that there have been changes in his workplace environment since the passing of the NJOPA. There have been policy and procedure changes, such as mandatory training videos and presentations, as well as the creation of a department policy on how to store and use naloxone. PO1 described the change in attitude and morale as "callous and cynical." He stated that as a police officer, he can see all the lives that drug addicts' affect. PO1 stated, "You don't look at them like victims, you look at them like the problem."

PO1 described his feelings on his last overdose call as "just another call." He sounded numb to the idea of saving a life of an overdose victim. In fact, he stated, "I don't think that euphoria of saving a life is going to feel as strong given the circumstances." He described how it's different saving the life of a drug addict and someone who chose to "inject poison" into themselves compared to an innocent family man who goes into cardiac arrest while doing yardwork. PO1 describes the behavior of a drug overdose victim as never satisfied. He stated

that they “all stay addicts” and that they will push their limit because there is no heroin too strong and the use of naloxone serves as an “insurance policy” or “backup plan” for them. He recommended that there be some type of repercussion attached to the NJOPA that is not necessarily jail time, but perhaps a mandatory drug court or rehab, or anything that holds them accountable in some way.

PO2

PO2 is a police officer who currently works for a police department within C1. PO2 had prior experience as a police dispatcher with a different police department within C1, but that experience was not counted towards data analysis. PO2 holds a Bachelor of Arts degree and has a total of 10 years of experience as a police officer. He stated that he has responded to a total of six overdose calls since the passing of the NJOPA.

PO2’s knowledge about the NJOPA is that it provides immunity to the caller and/or the overdose victim from criminal prosecution. PO2 extended that knowledge to say that if there is evidence of drug trafficking or other extreme examples that lead to death, the NJOPA may not provide that criminal immunity. PO2 did not know when the NJOPA was enacted and stated that he does not think drug users know about the NJOPA either. However, he did say that drug users know that “everybody’s carrying naloxone now” and that it is very effective at saving lives.

PO2 stated that there have been changes in his workplace environment since the passing of the NJOPA. PO2 works for an accredited police department, which means there is a national and local standard that must be met in regards to policies, procedures, infrastructure, equipment, etc. Therefore, they have a naloxone policy that follows the NJ Attorney General’s guidelines and they have to fill out an additional naloxone deployment form. When he first received training on naloxone, he was directed to give it to anyone who he thought might need it because

it has no negative side effects on a healthy individual. There is now a policy and training in place for when/how to use naloxone appropriately. In regards to attitude and morale, PO2 noted that his police department consists of “young guys” and that since they do not know anything else or better, there is no opposition to the NJOPA. He noted that senior police officers have a different, more cynical attitude, about the NJOPA and states that some officers have said, “Why are we even saving these people?”

PO2 described the scene on his last overdose call as hectic and his feelings as indifferent. He states that, “You kind of feel like it’s worthless. I’m not doing an investigation...I don’t feel like I’m really doing my job.” He also noted that it’s not like a typical CPR save where he feels happy for saving someone’s life because that person is genuinely happy to be saved and grateful to him. He stated that on an overdose call, the victim doesn’t even care that he saved his/her life. PO2 stated that the behavior of a drug addict after being saved is that they will continue to use, and most likely get arrested in his/her town or a neighboring town for possession of drugs. He recommended that the NJOPA has some type of repercussions to “break the cycle” of the victim. He was unsure if it should be punitive or rehabilitating, but he stated that it is a good law with the intention of helping people, which is what the police should do. He also suggested that the actual naloxone unit be easy to administer.

PO3

PO3 is a police officer who works for a police department within C1. PO3 had prior police experience at another agency within C1, but that experience was not counted toward data analysis. PO3 holds a Bachelor of Arts degree and is in his 14th year as a police officer. He has responded to an estimation of between 10-20 overdose calls since the passing of the NJOPA.

PO3's knowledge about the NJOPA was limited. His first response was that it required police officers to use naloxone. Then he clarified by saying that he knew he couldn't charge someone criminally anymore for an overdose if it was called in, but forgot that it was the result of the NJOPA. PO3 stated that when naloxone was first implemented, he received poor training and was told to "squirt here and squirt there." It is worth noting that his agency is not accredited. However, since new administration took control, they are in the process of writing a naloxone policy.

In regards to workplace changes since the passing of the NJOPA, PO3 stated that there is the practice of keeping the naloxone with the AED and treating an overdose call as a medical call. He stated that there is one internal form that he must complete, but nothing too extensive yet. He stated that the attitude within his department is that it is just one more thing that a police officer has to do. He states, "There's a lot of our job that's robotic and you just say, 'Okay.'"

PO3 described his last overdose call as exciting, nervous, joyful, a relief, and then anger. He described the victim as cold, with blue lips. He noted that every call is different and that he never knows what's going to be behind the door when he walks inside the house. When PO3 saves a life, he describes it as a big relief and "weight off his shoulder." PO3 could not describe the behavior of an overdose victim other than him/her not being honest, even when they know they cannot be charged. However, he did note that prior to the NJOPA, he arrested a man for overdosing. When he saw him years later, that man thanked PO3 for arresting him because it resulted in him "getting clean." He stated that he wished policy makers would consult with police officers and the people who actually administer naloxone and respond to drug overdose calls, but did not know what changes to recommend.

PO4

PO4 is a police officer who works for a police department within C2 and has a total of five years of experience as a police officer. He holds a Bachelor of Science degree and stated that he has responded to an estimated 13-15 overdose calls since the passing of the NJOPA. His knowledge of the NJOPA was that it was implemented in 2013 and that there is no criminal prosecution against a person who dials 911 for a drug overdose. The NJOPA was enacted before he went to the police academy and he stated that he did not receive any training on the existence of or reason for the law. He received training on the how to administer naloxone and the medical benefits of it while in the police academy.

PO4 was hired after the NJOPA was law and stated that his agency is accredited. His agency has a naloxone policy, naloxone training, and a “Narcan (naloxone) Deployment Form,” which must be completed after every use. Additionally, he stated that his agency is trying a new program possibly called “OD Mapping” in which they track the location of every overdose. Overall, his department has a positive attitude toward the NJOPA and use of naloxone and he stated that he treats an overdose call as just another medical call.

PO4 described his feelings on the last overdose as indifferent. He stated that he wasn’t mad, angry, or happy. He stated that the person who called the police was angry at him for not getting there faster and administering naloxone fast enough. He described the situation as chaotic and crazy because not only was he trying to save a life, but he had to deal with a lot of yelling and screaming from bystanders. PO4 described the behavior of an overdose victim as habitual offenders and stated that they usually get charged later on for possession. He noted that it is only when they get arrested that a drug user thanks the police for getting them “clean.” PO4 recommended that the police and politicians need to do a better job educating the public on the

NJOPA and the fact that a person can't be charged criminally if they call 911 for medical attention. He stated that the NJOPA does a good job saving lives, but perhaps more lives could be saved if everyone knew that they would not be charged.

PO5

PO5 is a police officer who works for a police department within C2 and has a total of 3 years of experience as a police officer. He was previously a police officer for a short time in a police department within C1, so his responses and experiences within that agency were counted towards data analysis. He holds a Bachelor of Arts degree and has responded to approximately 40 overdose calls since the passing of the NJOPA. His knowledge of the NJOPA is that a person can't be charged criminally if they call 911 for medical assistance for an overdose. The NJOPA was enacted before he went to the police academy and he stated that all his training and knowledge about the NJOPA was from his field training officer and on the job experience. His knowledge about the use of naloxone was limited, but he did state that it is effective at saving lives and that whoever gets on scene first should administer it, whether it's police or Emergency Medical Service (EMS).

PO5 works for an accredited agency and stated that his agency has a naloxone policy and training. PO5 must complete a form every time naloxone is used. He stated that they recently started using a new form that is very detailed and tracks specifics in regards to the heroin and paraphernalia located on scene, as well as a new website that tracks overdose locations. In regards to attitude and morale, he stated that he works on a squad with a lot of junior officers and they are all positive or indifferent about the NJOPA and use of naloxone. He stated that senior officers had "salty" attitudes and wish they could charge someone for overdosing.

PO5's last experience on an overdose call was described as an adrenaline rush and then an adrenaline dump. It was at a rehabilitation house, which was full of recovering addicts, and after he administered naloxone, the overdose victim recovered within 45 seconds. However, he noted that he was upset because the person whose life he had just saved was upset with him. PO5 stated, "That's something that's annoying about overdoses because sometimes you'll literally save their life and they're mad at you that you took away their high from them."

PO5 stated that the behavior of an overdose victim after being saved by naloxone and not being criminally charged is "never appreciative" and stated, "...sometimes it seems that they're taking advantage that they could just get Narcan (naloxone)." He also noted that many people that have overdosed get charged later for possession or shoplifting. Overall, PO5 thought that the NJOPA was serving its purpose and is saving lives. He stated that, "I think it's good the way it is."

PO6

PO6 is a police officer who works for a police department within C1 and has a total of six years of experience as a police officer. He has been a certified EMT and volunteer firefighter for the previous 10 years, but his experiences of overdose calls while serving in those capacities were not counted towards data analysis. PO6 worked in another agency within C1 before his current agency. Although his time in that agency counted towards this research, he stated that it only dealt with the other side of policing, such as court security, for example, so that experience was not relevant to this study. PO6 holds a Bachelor of Arts degree and stated that he had responded to more than 20 overdose calls since the passing of the NJOPA and that he has administered naloxone over six times. PO6 has a unique perspective due to his experience

beginning his EMT career at the local hospital and working his way up through the police academy and current position. He also serves as his police department's naloxone coordinator.

PO6 was hired after the NJOPA was enacted, but stated that it was signed by Governor Christie and that it provided criminal immunity for certain offenses to people who either witnessed or were the victim of a drug overdose. He stated that naloxone is a very effective tool for saving lives and also believed that the NJOPA is effective in the short-term at saving lives. PO6's agency is not accredited, but he stated that they still have a policy on overdose calls for when there is the use of naloxone and when the NJOPA applies. There are mandatory forms that must be completed and sent to the County and the State; however, there is no longer an investigation and drugs and paraphernalia are seized only for destruction. Additionally, PO6 noted that attitude and morale was negative in the beginning when the NJOPA was enacted and that a lot of senior officers felt that the person should be charged criminally. However, PO6 described the current workplace attitude as,

...just another call for the guys now. We have a more aggressive patrol and we have a bunch of new guys. And what I've seen too since I started is we may have Narcanned you today and we couldn't charge you today, but when we see you driving down the street next week, we're going to recognize you and we're going to stop your car and try to find something more to dig with. And a lot of people that we've Narcanned have gotten arrested by us subsequently. (PO6, 2020)

PO6 described his last overdose call as different from the usual because it involved a regular drug user who they had saved two or three times in the past month. However, as soon as he rendered medical aid and used naloxone on the victim, the victim's girlfriend admitted that she threw the needles outside of the home. He "switched gears" to evidence gathering because she

lived next door to a high school and his main concern was that children could find the needles or get pricked by them and potentially become infected. Although he screened the case for criminal charges against the girlfriend, which were ultimately denied by the county prosecutor, he stated that he later arrested the victim a week later on a traffic stop for drug possession. Overall, PO6 felt that the NJOPA and naloxone are very effective at saving lives. However, if naloxone is deployed, he felt that the victim should have to complete mandatory counseling or treatment, and if it is not completed, criminal charges should be issued.

PO7

PO7 is a police officer who works for a police department within C1 and has a total of 12 years of experience as a police officer. He holds a Bachelor of Arts degree and has responded to an estimated 10-15 drug overdose calls since the passing of the NJOPA. His knowledge of the NJOPA is that it was a law signed by Governor Christie early in his career that provided basic protections for people who contacted the police or the overdose victim during an overdose. He stated that it was intended to eliminate the fear of calling the police, and as a result, get a faster response time for medical attention. PO7 stated that the use of naloxone is definitely effective at saving lives and he thought that it was in some way attached to the NJOPA. However, he stated that naloxone is now an “expected drug” and stated that,

When we were able to use it, they were appreciative that we were able to reverse the effects. But now it’s almost like an expected drug. If we go to an overdose, people know what it is and know that we carry it and they just presume that we should be using it to reverse the effects. (PO7, 2020)

PO7 became a police officer before the NJOPA was enacted and stated that his agency is not accredited. He described the workplace environment changes in regards to policy and practice as

mandatory naloxone forms, training with videos from the Attorney General's Office, carrying the naloxone with the AED, and no longer doing any type of follow up. He described the attitude and morale of his workplace as positive due to the type of town that he works in. The police officers are young and energetic, and that senior officers do not have to get involved with much if they do not want to because the junior officers pick up much of the work.

PO7 described his last drug overdose call as one of the "frequent flyers" so his emotions were "relatively even keeled." He described it as frustrating in a way because the victim's parents expected the police to move faster and do more, instead of grasping the fact that their son overdosed for the third or fourth time. After he used naloxone on the victim and saved his life, he described it as frustrating again because the victim did not want to go to the hospital.

And I would say in that respect it could be a frustrating situation because he put himself in that predicament and doesn't even want to go to the hospital to be checked out fully and just expects that the Narcan (naloxone) will be good enough. (PO7, 2020)

PO7 describes the behavior of an overdose victim as continually using. He stated that some of the individuals that he follows up on "tell us that they'll buy Narcan (naloxone) in case it happens again." He states that,

They don't look at it as a problem. I think that's part of the biggest issue with what happens with drug overdoses. They don't try to get clean. They just look at the result of, I could just get Narcan (naloxone) and I'll be okay. (PO7, 2020)

PO7 noted that he does often arrest a drug overdose victim at a later date because he knows who they are; they are a small town where they "know the players." Overall, he believes that the NJOPA and use of naloxone is a good thing, but that there should be some type of community

service or drug education attached to usage, as well as mandatory medical transportation to the hospital after a person has received naloxone.

PO8

PO8 is a police officer who works for a police department within C1 and has a total of 5 years of experience as a police officer. He holds a Bachelor of Arts degree and has been on 30 confirmed drug overdose calls where he has administered naloxone personally. His knowledge about the NJOPA was that it was signed into law in 2013 and protected the caller and overdose victim from criminal charges. PO8 went to the police academy after this law was signed and he stated that he received no education on the NJOPA while in the police academy. All of his knowledge and training came from “on the job” training. PO8 had a different opinion on the effectiveness of naloxone than previous participants.

It really depends. Nowadays, you don't know what you're getting in a heroin pack. You're getting Fentanyl. I can be administering...Heck, I was just on a call. I had to give the guy two Narcans (naloxone) in the course of five minutes.

It just depends on the type of person, I guess their weight, like I said, I'm not a doctor, how many times they use it, and if they get a bad batch of Fentanyl. It just really depends. (PO8, 2020)

PO8 works for an accredited agency and stated that his workplace environment has procedures for carrying naloxone. He keeps his naloxone separate from his AED and stated that his department only has five naloxone units. On a busy night, there have been times where other officers may have to drive their naloxone to a scene, or return to headquarters to get another unit. There have been nights where the police have to ask the paramedics or EMT's to bring extra naloxone because they ran out of all five in one night. PO8 stated that his department has

younger officers, many of who were hired during the opioid epidemic - so they are used to the drug overdose calls. He stated that his attitude is pretty positive when he responds to a first-time caller and location, but that he loses faith and has low morale when he keeps responding to the same address for the same victim.

PO8's stated that each drug overdose call brings a different set of emotions. His last call was at a rooming house, a repeat location, but everyone had left the scene. It was also during the COVID-19 Pandemic, so he had to suit up with extra personal protective equipment (PPE), including a mask and a suit. However, he stated that aside from the changes due to COVID-19, he is numb to overdose calls. He states,

At this point, I've become so numb to it because I've done it so many times that if it was a 16-year-old or a 60-year-old, I would probably feel the exact same way going to a scene. It's almost to the point where I've done it so many times, I've become numb to it. As I said, for me, it's just the job. (PO8, 2020)

PO8 described the behavior of an overdose victim as fearless. He stated some do not know about the NJOPA and when he tells them that they are not in trouble, they are shocked that they are not going to jail. However, he stated that he will remember their names and the types of vehicle that they drive and monitor the house for "people coming and going." Overall, he stated the NJOPA is somewhat irrelevant. He believes that it serves as a "get out of jail free card" but also acknowledged that in his opinion, jail is not the answer. He believed that "at the end of the day, it's up to the person." It was also worth noting that due to the COVID-19 Pandemic, he has noticed a surge in drug overdose because "People are staying home. People are bored. People are trying new things."

PO9

PO9 is a police officer who works for a police department within C2. He holds the rank of a supervisor and is the only participant in a supervisory position in this study. He holds a Bachelor of Arts degree and has 15 years of experience as a police officer. He was a police dispatcher and EMT for five years prior to becoming a police officer and he has responded to approximately 25-30 drug overdose calls since the passing of the NJOPA. He described his knowledge of the NJOPA as “somewhat limited” and referenced a lot about the use of naloxone and that it is very effective at saving lives. He did not recall exactly, but stated that he received “informal” training on when to charge or when not to charge somebody with a drug offense, as well as how to use naloxone. PO9’s agency is not accredited.

PO9 stated that he still uses the old naloxone units, which have to be assembled. There is a department practice in making sure that each patrol officer signs out a naloxone unit and carries it in his patrol vehicle. He has to complete a naloxone use form and fax it to the County Prosecutor’s Office when it is administered. There is no longer any follow up or investigation of a drug overdose. It is mostly an open and closed case, unless an overdose results in a death. PO9 stated that his police department is mostly junior officers in their late 20’s and that that has an effect on attitude.

I think the more senior guys that we have, who were on prior to the law, went through a phase where it was, ‘Hey, this is bulls**t.’ And this had a really negative attitude toward it. I think that because we’ve been dealing with it, I don’t want to say for so long, but for the duration that we have that it’s kind of, it is what it is. (PO9, 2020)

PO9 described his last drug overdose call as “the usual.” He stated that it was a known drug user whose house he has been to before. The victim’s father was cursing at his son (who is unconscious) and the police. PO9 described the scene as,

...dude’s blue on the bed, he’s got folds (heroin) right next to him, not only did we expect it, but there it is, all the evidence that we needed that this is an opioid overdose, delivered Narcan (naloxone), wait about four minutes, delivered a second dose, he starts coming round...but comes around after about two minutes, has full mentation, full clear speech, “What are you guys doing here?” “Ah, you f**king used again?” “No, I’m clean.” (PO9, 2020)

PO9 went on to say that the victim’s father was mad at the police for never arresting him and taking him out of the house, but PO9 told him that there is nothing he can do because of the NJOPA. PO9 believed there should be some type of punitive action against the overdose victim. He stated, “I’ve literally heard it out of the mouths of users. ‘I don’t give a sh*t, you guys are just going to bring me back again.’” He stated that when other users find out about good heroin, they all want it to get that extreme high. PO9 felt that a possible solution would be to have a three strikes idea where the user would get charged criminally after a third overdose.

PO10

PO10 is a police officer who works for a police department within C2. He was hired as a police officer in 2013, the same time the NJOPA was signed into law, in a highly recognized urban city in southern NJ. He was also an EMT for 14 years and a volunteer firefighter for four years. He transferred to an agency within C2 and stated that he has been to over 100 overdose calls as a police officer and EMT. For the purposes of this research, only his experiences for the

last four years as a police officer in C2 were analyzed. PO10 holds a Bachelor of Arts degree and works for an agency that is not accredited.

PO10's knowledge about the NJOPA is that it was meant to encourage people to call 911 to get medical care for someone who overdoses without the fear of arrest for themselves or the victim. Even though he went to the police academy the same year the NJOPA became law, he stated that it was not discussed in the police academy. He had experience with naloxone as an EMT and police officer and feels that it is very effective at saving lives. He believed that naloxone used by police officers is part of the NJOPA because "pretty much every agency is administering it at this point."

PO10 stated that his workplace environment has changed after the implementation of naloxone because they now have a policy on the proper methods of storing it within the police vehicle, the forms that need to be completed after use, and how to give victims information cards with resources after they overdose. PO10 stated that he has never run out of naloxone units in one night in his current agency; when they run low on units, they go to the hospital that they have a contract with to get more. PO10 stated that the attitude in his workplace towards the NJOPA and use of naloxone is positive because they are a younger department and "they embraced it basically."

PO10's last experience on a drug overdose call had a negative outcome for the victim. He stated,

It's just a regular day thing for me. But I mean the last one was a fatal and it came out as a possible overdose. So, we hauled a** over there like we usually do. By the time we got there, the husband was out at the front door...I found out that we did Narcan (naloxone) on her once before, but I was never there. I locked her

up on a warrant...So he's like, 'I think she's back on drugs. She just got out of a rehab program. She got sent home'...So we went upstairs, she was long gone...she was blue and cold. (PO10, 2020)

PO10 administered naloxone anyway, based on the time frame of when the father, who also lived there, said he saw her last, but it was ineffective. He stated that it is "always sh*tty" to tell a family member that their loved one has died, but he has seen it so regularly that he is numb to it.

PO10 stated that his experience with overdose victims is that they break into abandoned houses to steal copper or break into cars to steal things to sell and get money for their habit. However, one user that recognized him while he was off-duty, came up to him and said, "Yeah, I know you...you Narcanned (naloxone) me, and then arrested me a week later...I got my sh*t together after that." PO10 thought that it was a good thing police officers carried naloxone, especially in C2 where a paramedic could be "15, 20, 25 minutes away" and the police could be there very quickly. He thought the only thing that could make the NJOPA better was to make the overdose victim received support through a mandated rehabilitation, as opposed to leaving the decision up to each county separately. Something to note is that PO10 stated he noticed an uptick in drug overdoses, possibly caused from the COVID-19 Pandemic. He stated,

I mean at this point everybody's stir crazy and looking for things to do. I know at least one of our overdoses was actually in a drug treatment program and sent home because of all this (COVID-19) and then overdosed. (PO10, 2020)

The current COVID-19 Pandemic has had a negative effect on drug overdoses according to PO10.

Part Three: Emergent Themes

This researcher attended to emergent themes to understand the experiences lived by police officers who work in two centralized counties within the State of New Jersey. Each of these participants responded to drug overdose calls since the passing of the NJOPA and administered naloxone. Initially, 15 themes emerged after analyzing the data received from each of the 10 participants who told their stories about their experiences as a police officer since the passing of the NJOPA. The 15 themes were further coded and five main themes emerged. From the five overarching themes, 15 subthemes were identified to allow for specifics to be highlighted within general topics. Not all participants experienced each subtheme, but the repeat occurrence of responses supported triangulation, or identification of patterns, in the data from multiple participants, which provided an understanding of the experience (Merriam, 2009). COVID-19 was mentioned towards the completion of data collection and was included under the Environment subtheme. Table 2 shows the five main themes and 15 subthemes that emerged from data analysis.

Table 2

Police Officers' Experiences on a Drug Overdose Call: Themes and Subthemes

Themes	Subthemes
THEME #1 NJOPA and Naloxone	Naloxone effectiveness No training in the Police Academy Naloxone administration and recidivism Naloxone and criminal immunity
THEME #2 Change in Police Procedures	Scene management Naloxone carried with automated external defibrillator (AED) Naloxone deployment form and paperwork

THEME #3 Relationship between Police Officers' Attitudes and Their Years of Service	Pre-NJOPA officers' attitudes Post-NJOPA officers' attitudes Repeat offenders and police officers' attitudes
THEME #4 Factors that Change the Experience of an Overdose Call	Victims' actions Callers' actions Environment
THEME #5 Police Officers and Overdose Victims after an Overdose Call	Overdose victims' identifiers, actions, and police memory Overdose victims' attitudes perceived by police officers

Theme 1: NJOPA and Naloxone

This theme was selected because all ten participants expressed some degree of knowledge about the NJOPA and the use of naloxone, however, each participant had a different level of knowledge about the NJOPA and some thought that the use of naloxone was the NJOPA. There was a 6:4 ratio of police officers who were employed as a police officer after the NJOPA and before the NJOPA respectively. The level of knowledge about the NJOPA by each officer may be a factor reflecting formal training or lack thereof. All 10 participants agreed that naloxone is effective at saving lives immediately during an overdose. To sum up the difference in knowledge about the NJOPA by police officers, compare PO2's response to PO3's response when asked about their knowledge of the NJOPA. PO2 stated, "It (NJOPA) provides immunity to anybody that calls when there is an overdose...if somebody needs medical assistance due to a possible overdose, they basically get immunity, the caller and typically the overdose victim." PO3 stated, "Pretty much nothing, other than when you arrive on scene, you administer Narcan (naloxone) if you suspect an opioid overdose." Four subthemes: (a) naloxone effectiveness;

(b) no training in the police academy; (c) naloxone administration and recidivism; and (d) naloxone and criminal immunity, are described below.

Naloxone effectiveness. Every participant in this study administered naloxone to an overdose victim at least once. Nine out of ten naloxone administration experiences resulted in saving the victim's life. The one victim who passed away was deceased long before PO10 arrived on scene, but he administered it anyway based on statements made by the caller and conflicting time frames of when the victim was last seen alive. Each participant's knowledge about how naloxone worked medically was different, but they all stated that naloxone is effective at saving lives. PO4 stated, "I think it's a very effective way, but people don't realize how long it takes to actually kick in." When PO5 was asked if naloxone is effective at saving lives, he stated, "Absolutely" which echoed the responses of all other participants.

No training in police academy. Six police officers were hired before the NJOPA was signed into law, and thus, would not have received training in the police academy on its history or the reasoning behind the law. However, of the four police officers who were hired and went to the police academy after the NJOPA was law, not one received training on the NJOPA. PO8 summed it up with,

So, I had pretty much no training on the act in the academy. When I was on the job going through FTO (Field Training Officer) and, obviously just going to calls, that's where I learned that we're not charging people for overdosing or people that are there, we're not charging those types of people. (PO8, 2020)

All four police officers stated that they received their knowledge about the NJOPA from their field-training officer and on the job experiences.

Naloxone administration and recidivism. Although all participants felt naloxone is effective at saving lives, and all believed that a police officer's job is to save lives regardless of the situation, many police officers felt that naloxone does have a long-term side effect to the victim and society. PO1 stated that,

They always seek something stronger because they try to push their limits because at some point a heroin addict or a drug addict, they throw away all rationale about what's important to them in their life. All they care about is their next fix and trying to get the best high that they can get...So the fact that naloxone or Narcan's out there may give them an insurance policy that at the end of the day they know that would be a backup plan for them. (PO1, 2020)

Common responses from participants were phrases such as "insurance plan" or "backup plan." PO6 stated, "I think long-run though, for helping the person [to] get the help they need, I think it's a crutch..." As a result of this repetitive cycle of using, overdosing, naloxone, using, overdosing, naloxone, a toll is taken on the police officer and the victim, which will be discussed in the "police officers and overdose victims after an overdose call" theme.

Naloxone and criminal immunity. Each participant, except for PO3's initial response as noted above, was able to explain their knowledge about the NJOPA and naloxone respectively. However, when asked the follow-up question during the semi-structured interview, some participants believed that the NJOPA required that police officers administer naloxone, in addition to the criminal immunity provided to the victim. For example, PO10 stated, "I would say it's part of the (NJ) OPA just because every agency is administering at this point. PO6 was not sure if naloxone was required by the NJOPA but stated, "it was a directive from the County that came out after the NJOPA to implement that (naloxone)." PO7 stated, "I think it's probably

part of the act.” And PO4 stated that he was not aware of anything in the NJOPA that required the use of naloxone because it is unknown a lot of times if it is indeed an opioid overdose call.

He states,

I know on times, even on medical calls, say we go to a call for an unresponsive male, no one knows if he has a drug habit. Maybe he does. You can still give Narcan (naloxone) and it’s not going to affect him.

Theme 2: Change in Police Procedures

Needless to say, some type of change is expected when there is a new law in effect. It is the degree of change and repeated responses by participants that helped this main theme emerge. Some of the changes would be expected, but other responses to the same question varied in some way. This is most likely the result of working in a different police department or county that may have a different set of policies and procedures. Nevertheless, it is important to identify these themes and how a police officer’s lived experience has changed since the implementation of the NJOPA and use of naloxone. The following three subthemes emerged (a) scene management; (b) naloxone carried with automated external defibrillator (AED); and (c) naloxone deployment form and paperwork, and are described below.

Scene management. Because the NJOPA provides criminal immunity to the overdose victim, there is no need to gather evidence or schedule a court appearance. Prior to the NJOPA, when a police officer arrived on scene of a drug overdose, he would first render medical care, but then treat the situation as a crime scene because there is evidence to be collected for prosecution. For example, a police officer would canvass the area thoroughly and collect any heroin or paraphernalia for placement into evidence. The heroin would be sent to the New Jersey State Police lab and tested for illegal substances. The results would be included in the case file for the

prosecutor when the overdose victim went to court. That procedure has now changed. PO6 stated that most of his overdose cases are “shut and closed.” PO5 repeated that experience and stated that “An overdose itself, the report is pretty much closed out...” although he was not sure about follow up from the Detective Bureau. PO4 stated that after an overdose call and while on the scene, he gathers the evidence, but that it is destroyed later on.

There are participants that stated, although evidence is collected on scene to be destroyed, follow-up is done, should the overdose result in death or is possibly a part of a major drug trafficking case. For example, PO7 stated,

When it comes to overdoses, our detectives will often do a track flier and be in contact with the State Police lab, because often times, even though we’re not charging them, they like to track overdoses, especially with stamps. (PO7, 2020)

PO7 was referring to the logo on the wax fold that heroin is contained in. When multiple people die in different locations, but they have the same wax fold with the same stamp, it could be useful to track that information and find out where the supply is from.

Naloxone carried with automated external defibrillator (AED). Most participants stated that they carry the naloxone with their AED. Most police departments already had a policy that mandates each officer carry an AED in their patrol car in the event someone needs advanced lifesaving procedures performed. The majority of police officers stated that because a drug overdose is now treated like a medical call, rather than a criminal call, it only makes sense to carry the naloxone with the AED. Nine out of ten officers stated that they always have enough naloxone and that there was never a time when they did not have naloxone in their patrol vehicle. However, PO8 stated that he works in a high overdose town and that they only have five naloxone units per squad. When his squad is fully staffed, he has four officers. He stated,

Our policy is that we have at least two Narcan's (naloxone) on a shift...I've actually had cases where we've had multiple issues of having to administer it and we have to have somebody else go back into the squad building to get the other dose...I've actually had times too, where the paramedics have come on scene and we've completely ran out and we've have none. We'd have to ask the paramedic from the hospital if they had any extras. (PO8, 2020)

The physical carrying of naloxone is a change in the daily practices of a police officer. In addition, the way that it is signed out and the location that it is stored was identified to help alleviate the possible problem of not having it available throughout a patrol officers shift.

Naloxone deployment form and paperwork. There appeared to be difference in naloxone procedures between police departments after it was administered. Although every participant stated that they received training on how to administer naloxone, certain naloxone units were different than others. Some came preassembled and were easy to use by simply spraying into one nostril. Others had to be assembled while during the stressful scene of a drug overdose and a certain amount of dosage had to be sprayed into each nostril separately. Furthermore, two police officers stated they now input information into a website called "OD Mapping" which logs the location of overdoses and other information instantly.

The following is a comparison of the different procedures experienced by police officers after naloxone is administered: PO8 stated, "We do the Narcan (naloxone) report form, we send it to the ROIC, we send it to the prosecutor's office, and that's really it." PO2 stated, "The only thing they really tell us and push us is we have to fill out an additional form, so we can basically get the new Narcan to replace the old one." Whereas PO4 said,

We have to fill out a Narcan (naloxone) deployment form, which includes the lot number and saying how many doses of Narcan you administered, how long it took to work, and the outcome of the patient...Then we have a new program called OD Mapping...It's a pilot. It's a new website from the State Police, I believe, and it tracks all the overdoses in live time with stamps. (PO4, 2020)

These statements show the differences and similarities in what each agency and county may want in regards to procedure after naloxone is administered. The minimum appears to be some type of naloxone deployment form, whereas the more progressive departments are using advanced software.

Theme 3: Relationship between Police Officers' Attitudes and Their Years of Service

There is a common saying in the police profession that a senior or veteran patrol officer is "salty." This generally means that he is angry, irritable, and bitter. When discussing police officers' attitudes among participants, the majority stated that "we are a young department, so it's pretty good." Most police agencies offer some type of critical incident stress management or employee assistance programs for police officers, regardless of years of service, who need or want psychological help. However, there seemed to be a variation in the way a senior officer spoke during an interview versus a junior officer. The difference was not only in regards to what they were saying, but the way they were saying it such as tone, language, and attitude. Attitudes towards the NJOPA and use of naloxone were identified by the participant and for their agency as a whole. As a result, the following three subthemes were identified: (a) Pre-NJOPA Officers' Attitudes; (b) Post-NJOPA Officers' Attitudes; (c) Repeat Offenders and Police Officers' Attitudes.

Pre-NJOPA officers' attitudes. Six participants were hired as a police officer before the NJOPA became law and naloxone was carried and used by police officers. The most senior participant, PO9, stated the following,

I think the more senior guys that we have, who were on prior to the law, went through a phase where it was, "Hey, this is bulls**t." And this had a really negative attitude toward it. I think because we've been dealing with it, but for the duration that we've have, it's kind of, it is what it is...And I think part of that is back in my day...these a**holes used to get charged, and now they get off scott free. Now they're conning us. (PO9, 2020)

Additionally, PO2 stated that, "Our department...is predominantly younger guys, and young don't know anything otherwise. We will see some of our more experienced are more opposed to the whole Overdose Prevention Act in that they're like, 'Why are we even saving these?'" PO1 stated that,

Once this Act came into effect, a lot of police officers that I work with really felt strongly that's it's not our job to play God, if these people want to inject poison into their bodies, knowing the repercussions, who are we to prolong the inevitable? (PO1, 2020)

Other keywords and phrases stated by participants that described their officer's attitudes included "frustrated," "callous," "oppose," and "gun-shy."

Post-NJOPA officers' attitudes. It is not possible to ask someone who was not a police officer prior to the NJOPA to discuss how their attitude or morale was then compared to now, however, PO5, who is the youngest participant, summed it up well when he stated,

To my experience, I'm on a very young junior squad so we don't really have an opinion on how it was compared to how it is now. But there are some guys that I've been on calls with that are...pretty salty that they can't charge someone else on scene or whoever the caller is. (PO5, 2020)

In regards to his own attitude, he stated that, "It's kind of just how we got brought up in it, so I'd say the morale's pretty good." PO4 is the second youngest participant in this study and described his workplace environment's attitude by saying, "I don't think anyone's negative towards it. If someone has an addiction problem and they need help and sometimes they have a bad day and overdose and you got to go help them..." Although the NJOPA was not taught in the police academy, according to any of the participants, it still appears that they have a rehabilitative approach and view an overdose call as a medical call, and as a result, have kept a positive attitude. However, in the final subtheme of this category, police officer attitude starts to change regardless of their years of service as will be described below.

Repeat Offenders and Police Officers' Attitudes. Although participants attitudes about the NJOPA and use of naloxone varied depending on their years of service, they could have also changed over time or with overdose victims who recidivate. For example, PO7 stated, "We're a relatively younger department, but I think for the most part, our older officers have adapted to it." PO6 stated, "I think it's just another call for the guys now...And a lot of people that we've Narcanned have gotten arrested by us subsequently." And PO8, who was hired after the NJOPA was law, stated that

I feel like since I've gotten on, heroin has been extremely prevalent where I work. I think the older guys, I don't think they saw a lot of it as they were coming up...I've had two friends actually overdose on heroin, so it kind of hits home for

me...I've been to homes more than two or three times for the same person administering it. I'm just like wow, when does it come to the fact that you hit rock bottom and you have to figure out that enough is enough? (PO8, 2020)

PO8 agreed that the first-time caller and first-time location results in a positive attitude, but when a police officer goes back to the same address and sees the same person as he did, the police officers started to lose morale.

Theme 4: Factors that Change the Experience of an Overdose Call

Naturally, each participant had a different lived experience on his last overdose call. Emotions were wide ranging and a descriptive experience was captured as best as possible. It should also be noted that COVID-19 was mentioned during two of the latter interviews, and those responses were included as part of this broad theme. In doing so, the following three main subthemes were identified that contributed to the overall experience for a police officer on scene of a drug overdose: (a) victims' actions; (b) callers' actions; and (c) environment.

Victims' actions. Participants described victims' actions during their description of a drug overdose call. Sometimes the victim's actions that led up to the overdose were described by the police officer, sometimes the victim's physical status while overdosing was described, and sometimes the victim's actions after they were administered naloxone were described. Nevertheless, the victim's actions played a major part in the overall experience of a police officer. PO5 described his last overdose call as an "adrenaline dump." He stated that it was at a recovery house where they normally respond to for overdoses. He was "excited" because he was the first one there; he saw the victim on the ground, unconscious, with agonal breathing and a faint pulse. PO5 gave him a dose of naloxone and the victim,

started to talk and he was upset that we woke him up, he was one of those, which is annoying. That's something that is annoying about overdoses, because sometimes you'll literally save their life and they're mad that you took their high away from them. (PO5, 2020)

PO7 described his last overdose call as one with a victim who was a "frequent flyer" and someone that he knew had previously been administered naloxone, which resulted in his response as "pretty even keeled," with lack of emotion. PO1 stated that a drug overdose is "just another call," meaning that there is no excitement or appreciation for saving the life of an overdose victim as there would be the life of an unsuspecting victim. He stated, "I don't think the euphoria of saving a life is as strong given the circumstances...when you see all this drug paraphernalia laying around..."

Callers' actions. One of the goals of the NJOPA was to decrease the fear of arrest for someone who calls the police for medical attention during a drug overdose (Hoffman, 2013). Some participants described the caller's actions after they arrived on scene of the overdose. The caller plays an important role in the overall experience because in all 10 participants' experiences, the overdose was called in by a third party and not the overdose victims themselves. PO4 stated,

Each call's a little different, but I feel like I'm not mad, I'm not angry, I'm not happy. Whoever the person's with is more angry at you because you're not Narcanning him fast enough and it's not working enough. So not only are you trying to do life saving measures, you're trying to dissolve the situation because she's just yelling and screaming in your face that he's dead. (PO4, 2020)

PO6 described a similar experience. He responded to the same address for the third time and was confronted by the caller and victim's girlfriend, who was "freaking out to the point of Narcan (naloxone)." The caller then told him that she threw the needles outside next to the high school. PO6 stated, "So that kind of triggered me a little bit to being angry."

PO9 stated that when he was dispatched to the address of his last overdose call he said, "Oh sh*t, we've been here before...we go in, mom and dad are in the house as usual. Dad's bitching...he's cursing at his son, he's cursing at us." PO9 felt the caller's frustration; he wanted his 30-year-old son to get clean and out of the house and he looked to the police for help, either through some type of forced rehabilitation or jail. PO9 could only tell the caller, "Dude, what do you want me to say? Don't call us, or don't let him back in the house." Therefore, the caller plays a role in the emotions that a police officer feels on a drug overdose call.

Environment. A police officer never knows what he is walking into. Dispatch might send a police officer on what may seem to be a routine call and everything can change for the worse or better when actually on scene. PO3 stated that his last overdose call was at a regular address, but the experience is different every time. He stated,

I don't want to say it's always the same, but every call we go to, you don't know what the hell you're walking into...So you get a report of an overdose at 123 Main St., you know what the house looks like outside, you don't know when you go behind that door what's going to be there, how many people are going to be there, what you're going to see, if someone's going to be panicking. So, there's always that adrenaline rush. (PO3, 2020)

PO7 stated that during his last overdose call, he "remembered showing up to the call and parents were yelling at us, basically knowing that we had Narcan (naloxone), telling us what to do.

Basically, telling us what we should do before we even get out of the car.” He said that a stressful environment like that makes it “frustrating” because it could make him move faster and run the risk of an error during naloxone administration protocol.

PO8 stated that the environment and address can make a police officer have different emotions and feelings depending on the call. For example,

There’s certain houses you go to you’re just like, ‘oh geez, not again.’ Then there’s houses that you’ve never been to and walk in, you’re like ‘wow.’ It can be a 300, 400, or \$500,000 house and someone’s overdosed and need Narcan (naloxone). You go to, like I said, a rooming [house] and, like I said, you’re more shocked when you go to those homes, but then when you’re going to like a rooming house and the same house over and over again, you’re just like, ‘It’s another overdose.’ (PO8, 2020)

PO8 personally lost friends to an overdose and admitted that it still shocks him how opioid addiction does not discriminate and it can happen to anyone regardless of socioeconomic status or the house that they live in.

Environment also includes the cultural and social environment at the time of this research. Towards the end of the interviews with participants, the COVID-19 impact within the State of New Jersey began to accelerate. PO8 described how COVID-19 impacted his last experience on a drug overdose call when he stated that,

I had to be extra cautious going in. I actually went in by myself. My partner stayed downstairs. I put on my gloves, my mask, my shield, my Tyvek suit. Walked in and he was laying supine on his bed. Like I said, he had agonal breathing. (PO8, 2020)

Normally, there is not a limit to the number of police officers on scene, but due to COVID-19, PO8 went in by himself in an attempt to limit the risk of exposure to the possibility of contacting COVID-19. The extra personal protective equipment (PPE) such as the mask, shield, and body suit are not normally required either. PO8 ended the interview with the following when asked if there was anything he would like to add,

No. I thought it was good. Especially with the whole COVID-19 now, people are staying at home, I'm definitely seeing a huge skyrocket in the use of it lately.

People are staying home. People are getting bored. People are trying new things.

(PO8, 2020)

PO10 stated "we had a rash of overdose deaths that Narcan didn't do anything for in (town)."

He added that he believed it could be a result of the COVID-19 restrictions imposed on the public by the government. PO10 stated,

I mean at this point everybody's stir crazy and looking for things to do. I know at least one of our overdoses was actually in a drug treatment program and sent home because of all this (COVID-19 restrictions) and then overdosed. (PO10, 2020)

Overall, although COVID-19 was only directly mentioned in two participants' responses, it was still worth documenting and including under this theme and subtheme because the future of COVID-19 is unknown and it may have a permanent effect on the way a drug overdose call is experienced by police officers.

Theme 5: Police Officers and Overdose Victims after an Overdose Call

Two subthemes emerged from discussing what happens after a drug overdose call:

(a) Overdose victims' identifiers, actions, and police memory; and (b) Overdose victims'

attitudes perceived by police officers. Key words such as “lethargic,” “angry,” and “unappreciative” were mentioned by the participants when describing the actions and attitudes of drug overdose victims after they were administered naloxone. Participants that were familiar with the victims after an overdose call also stated that some would get arrested for a “possession” charge later on. This was the result of several participants stating that although the victim could not get arrested due to the NJOPA, the participants would remember the name, address, and vehicle information of the victims in an attempt to monitor their behavior and possibly arrest them for illegal activity.

Overdose victims’ identifiers, actions, and police memory. Some participants stated that there is little follow up with the victim or that they were not sure about what happened to the victim after his/her overdose. However, PO2 stated that he saw one (victim) and she “acted like she cared. But she shortly thereafter got arrested within probably two weeks for the same thing, for having a bunch of heroin on her.” PO4 stated that he saw one person receive naloxone for overdosing, and then “the next day was arrested for possession.” PO5 stated, “I have come in contact with people that overdosed multiple times. They’re never appreciative and sometimes it seems that they’re taking advantage that they could just get Narcan.” He later went on to say that he did arrest someone that he used naloxone on before and he did thank him for that. PO5 also said he has arrested overdose victims later for “possession” and shoplifting. PO6 also stated that he knew of a victim he saved that was later arrested for possession of heroin, but ultimately died of an overdose.

Sometimes the police officer looks to make a proactive arrest based on the information that they remember from an overdose call. PO7 stated that he works in a smaller town and

“knows the players” so he might come in contact with them during a motor vehicle stop and “dig a little deeper” to find drugs. PO8 echoed the same action of some of the participants by stating,

It definitely raises the light bulb in my head. You definitely keep an eye out for them, especially a car they’re driving. You start watching the house, seeing if certain people are coming in and out of the house. (PO8, 2020)

Some participants indicated that there are ways around the NJOPA, as described above, if a police officer wanted to arrest that person at a later time for illegal activity.

Overdose victim’s attitudes perceived by police officers. The majority of participants stated that after an overdose victim receives naloxone, they are usually lethargic before they come to. Sometimes the victim may be angry that their high was ruined and other times they are in complete denial that they overdosed. PO1 stated that they just “care about the next fix” and that it is an “insurance policy” for them. PO3 stated that his last victim was “okay” and wasn’t upset with him that he saved his life, but that he was also confused and indifferent. However, PO5 stated that his last victim was “upset that I ruined his high” and that “not many” are appreciative towards him.

PO9 was upset that an overdose victim can refuse medical attention (RMA) after he or she receives naloxone. He pointed out that on a normal medical call, if a person is too intoxicated or under the influence to deny medical attention, medical transportation to a hospital is required by law. But on a drug overdose call, if a person is administered naloxone, they still have the right to RMA, which made no sense to him. He stated that if a person is well enough to RMA after overdosing, then they should be well enough to be arrested.

Conclusion

The purpose of this transcendental phenomenological study was to investigate how police officers describe their experience with responding to a drug overdose call since the passing of the NJOPA and use of naloxone. Other experiences such as changes in workplace procedures and attitudes were also discussed. Ten participants were interviewed and told stories about their workplace changes and responding to drug overdose experiences. The participants were from various local police departments within one of the two centralized counties within New Jersey. Originally, 15 themes emerged from data analysis, in which the following five main themes emerged: NJOPA and naloxone, change in police procedures, relationship between police officers' attitudes and their years of service, factors that change the experience of an overdose call, and police officers and overdose victims after an overdose call.

There was a 6:4 ratio among participants employed as a police officer before the implementation of the NJOPA and after the implementation of the NJOPA respectively. Responses varied regarding changes in workplace procedures and attitudes, most likely because of the specific agency, or county, that the police officer worked for. Furthermore, although attitudes differed, all participants took pride in their work and did their job to the best of their ability in order to save a life.

This researcher, who is a police officer himself, did not think of many of the themes that emerged from this study, which was a good indicator of successful Epoche. The differences in each participant's experience on a drug overdose, workplace procedure, or attitude, were still brought together by the fact that a police officer is a professional who took an oath and must do his job, regardless of what he personally believes. Additionally, all interviews ended with a "Recommendations" question, which was not part of any of the themes or subthemes developed,

and will be presented in the next chapter. Chapter 5 will discuss the findings and their significance, suggestions of how the results can be useful to stakeholders, recommendations to police chiefs and policymakers, and recommendation for further study.

CHAPTER 5

CONCLUSION

In 2018, 67,367 drug overdose deaths occurred in the United States. Opioids were involved in 69.5%, or 46,802, of those deaths. Two thirds of the opioid related deaths involved some type of synthetic opioid ([CDC], 2020). According to the CDC, the opioid epidemic can be explained in three waves: Wave 1: Prescription opioid overdose deaths; Wave 2: Heroin overdose deaths; and Wave 3: Synthetic opioid overdose deaths. The United States is currently in the third wave of the opioid epidemic ([CDC], 2019). (See Appendix A). In an attempt to combat this epidemic and save lives, policymakers and politicians shifted from a hardline punitive approach to a rehabilitative approach (Congressional Documents & Publication [CDP], 2015, 2016; Davis et al., 2013).

Good Samaritan Laws (GSLs) were one way policymakers thought would help save lives of drug overdose victims. Generally speaking, a GSL is specific to the state level, and is a law that addresses people who need medical assistance in some way. In New Jersey, the official title of the GSL implemented in 2013 to address the opioid epidemic is the “New Jersey Overdose Prevention Act” (NJOPA). While the law has been amended several times since its introduction, its initial function was to provide immunity from prosecution of any kind (indictable offense, disorderly person offense, local ordinance) when a person or persons are found in possession or being under the influence of a Controlled Dangerous Substance (CDS) when the police are called to an overdose scene (Hoffman, 2013).

Another way policymakers tried to reduce the number of opioid overdose deaths was to encourage the administration of naloxone by first-responders. Opioids kill people when the receptors in the brain change the behavior of the cells in ways that can slow or stop breathing

(Sanders, 2018). Naloxone is a medication that is used to block the effects of opioids, by reducing the respiratory and mental depression. It can be administered in various ways to the victim, but is most often administered intranasally by police or other first-responders on scene of an opioid overdose (Lavelle, 2014; Wermeling, 2015). In 2015, there was an amendment to the NJOPA that protected first-responders from being held liable when they administered naloxone to drug overdose victims. Although the NJOPA does not require police departments to carry naloxone, it does protect any officer who administers naloxone during his official duties (Davis, 2015).

While there are studies and data on the number of drug overdose deaths, GSLs, and naloxone, limited studies have investigated a police officer's perspective on the implementation of a GSL and the administration of naloxone. Specifically, little qualitative research exists concerning police officers' lived experiences on the scene of a drug overdose within the State of New Jersey since the changes were enacted in response to the way that a drug overdose victim is treated. Two research questions served as the basis of understanding to understand a police officer's lived experience on a drug overdose call:

1. Are there common lived experiences of police officers and paramedics who have responded to a drug overdose call since the passing of the NJOPA?
2. How do police officers and paramedics describe the changes in their workplace/procedures following the implementation of the NJOPA?

Although Ravitch & Riggan (2016) themselves admit that multiple definitions of "conceptual framework" exist, their definition of a conceptual framework consists of three main elements: (1) personal interests; (2) topical research; and (3) theoretical frameworks, is how this study approached this topic. This researcher's current career as a police officer in New Jersey and the

unique experiences that he has encountered, as well as the limited literature on GSLs and naloxone experiences of police officers, specifically in New Jersey, helped shaped the framework for this study. Additionally, the theoretical framework, which is found within the conceptual framework and can help connect the gaps between the conceptual framework and literature review (Ravitch & Riggan, 2016), approached this topic through the lens of moral hazard theory. Moral hazard theory applies to concepts that an individual acts in riskier behavior because they are insured and covered financially (Mirrlees, 1999; Rowell & Connelly, 2012).

In order to understand these phenomena through this conceptual framework, a qualitative study was completed. A transcendental phenomenological methodology was used to interview 10 police officers and record their lived experiences on a drug overdose call since the passing of the NJOPA and application of naloxone. Participants who were interviewed worked in police departments that were within one of two centralized counties in the State of New Jersey. After interviews were transcribed, they were member-checked by each participant. Data analysis followed Moustakas' (1994) three-step process: Epoche, Transcendental Phenomenological Reduction, and Imaginative Variation. Due to this researcher's personal experiences, this was helpful in limiting his biases and best realizing each participant's unique personal experience.

Initially, 15 themes emerged after analyzing the data received from each of the 10 participants who told their stories about their experiences as police officers since the passing of the NJOPA. This researcher then grouped the 15 themes into central themes based on their similarities. The result was the following five main themes: 1) NJOPA and naloxone; 2) change in police procedures; 3) relationship between police officers' attitudes and their years of service; 4) factors that change the experience of a drug overdose call; and 5) police officers and overdose victims after an overdose call. This chapter includes an interpretation of the findings, as well as

a discussion on the implications, and offers recommendations for actions based on the participants' responses and lived experiences.

Interpretation of Findings

Although participant experience and attitude varied depending on years of service, there were common themes provided by participants regardless of their years of service, specific police department, or town that they worked in. Every participant knew about the NJOPA and naloxone, but the degree of individual knowledge varied. Overall, the responses were mostly positive about the NJOPA and 100% of the participants agreed that naloxone is effective at saving lives. The findings as they relate to the two research questions are discussed below:

Are there common lived experiences of police officers who have responded to a drug overdose call since the passing of the NJOPA?

Yes. Every police officer stated that there is no such thing as a routine drug overdose call. Although every participant's experience was and always will be different, the common experience of a drug overdose call being unknown was a common bond. Nine out of 10 participants physically saved an overdose victim's life on their last overdose call with the use of naloxone. The victim's behavior after receiving naloxone was described by most police officers as "lethargic" or "indifferent," although some overdose victims were described as "angry" or "upset" because their "high" was ruined. Some also reported that the victim was in denial and would not admit to drug use.

Since the passing of the NJOPA, each police officer now describes a drug overdose call as simply a medical call. Emotionally, each police officer's experience differed, but three common factors of that experience emerged from this study: 1) Victims' actions; 2) Callers' actions; and 3) Environment. Sometimes, the victim was a first-time overdose victim and other

times he/she was a “regular.” The victims’ status did affect the emotions that a police officer felt during the call. For example, repeat offenders or repeat addresses appeared to have made the officer less stressed because they were there before or knew what to expect. However, all police officers felt a degree of excitement or adrenaline rush of the possibility of saving a life. One police officer described the saving of an overdose victim’s life as “emotionally weaker” than saving the life of someone who did not overdose. This suggests that it is possible to have different levels of the same emotions.

It is possible, although unlikely, that a person experiencing an overdose would call the police on themselves. All of the participants’ experiences of drug overdose calls were called in by a third party. Once the police officer is on scene, the caller’s actions can have an effect on his/her experience and emotions. The victims were usually described by police officers as unconscious with agonal breathing, sometimes with and sometimes without, drugs or paraphernalia around them. Sometimes the caller is on scene and other times they leave the scene prior to arrival. However, it appeared that when a caller remained on scene, it added more stress to a police officer during administration of naloxone. Often times, the caller was described as “getting in the way” or “yelling at the police” what to do. This often times turned a simple naloxone administration by the police officer into a chaotic scene that slowed the process down, because the police officer had to worry about his own safety and security, while trying to save the life of another person. In one example, the caller blamed the police officer for not arresting the victim (his son) and getting him out of the house. This can add to the emotional distress of a police officer.

The environment itself also plays a role in the experience of a drug overdose. Police officers described calls to the same place repeatedly as lowering the emotion to “here we go

again,” as compared to possibly a first time location that the officer has not been to. The difference in environments for the same type of call made an officer understand just how widespread and indiscriminate the opioid epidemic is. Additionally, the COVID-19 Pandemic added an entirely new set of emotions because the police officer now had to worry about possibly being infected with the virus, as well as making sure he put on the proper personal protective equipment before entering the home. The number of police officer or emergency personnel who entered the house was also limited, so the feeling of safety was diminished. Two participants also noted that they noticed an increase in overdoses due to social changes resulting from COVID-19.

Police officers often times felt frustrated or discouraged by the rate of recidivism of a drug user or the lack of punishment as a result of the NJOPA. Some police officers noted that although the victim cannot be charged today, their name, address, and vehicle could be monitored by police officers in the future as a means to develop probable cause and arrest them after a standard traffic stop. It should be noted that reasonable articulable suspicion exists due to the drug overdose call and experience of the police officer, but the legal standard of probable cause must still exist in order to make a legal arrest. At no time did a participant suggest making an arrest based on no probable cause or reasonable articulable suspicion that led to the probable cause. Moreover, the majority of police officers described the overdose victims’ attitudes as “indifferent” and “unappreciative” after their lives were saved and they were not charged or taken to jail by the police officer. Most officers agreed with the concept of the NJOPA, although some thought it could be amended in some ways because they described the use of naloxone and the NJOPA as a “crutch” or “insurance policy” for the drug user to rely on as he/she searched for their next “high.”

How do police officers describe the changes in their workplace/procedures following the implementation of the NJOPA?

Workplace procedures varied according to the police department and county that the participant worked in. Although a minimum requirement was met as far as required forms that needed to be completed and sent to their respective county prosecutor's office after the administration of naloxone, some agencies went above and beyond the standard. For example, the majority of police officers stated that they physically carry naloxone with their automated external defibrillator (AED) in their patrol car. Every officer stated that they have enough naloxone to start their shift, but one stated that he has run out because of multiple overdoses or administrations in one night. However, while many participants stated that they simply fill out a "naloxone administration form" and fax it to a higher agency, some participants stated that they input the data into a new program that tracks overdoses statistics in live time with detailed maps and information. Furthermore, many participants stated that while on scene after an overdose call, drugs and paraphernalia are collected for destruction and not evidence. Some participants stated that they collect drugs and paraphernalia as well, but it is then analyzed and recorded to possibly determine the supplier at a later date, if multiple overdoses occur with the same type of drug packaging. This change in workplace procedure, like responding to a drug overdose call and collecting the drugs for destruction instead of prosecution, did have a negative effect on attitude and morale as some officers stated that it is "a waste of time" or "what's the point?"

There was a common theme that emerged regarding workplace morale and attitude. Most senior police officers who were hired before the NJOPA had a more negative attitude towards the job and NJOPA than the junior police officers. Yet, they still acknowledged that it does save lives. Junior police officers more often felt that the NJOPA was a good thing and viewed it as

simply a medical call. However, they did not have the experience of charging someone criminally before it was enacted. Of all the police officers that were hired after the law was enacted, no one received any formal training on the NJOPA during their police academy training, and they all stated that their knowledge and training came while they were on the job. Another common theme emerged that, regardless of the number of years on the job, a police officer felt discouraged or unhelpful after they administered naloxone multiple times to the same victim.

Implications

This study highlighted several similarities in workplace procedures and police officer attitudes since the passing of the NJOPA and administration of naloxone. The two research questions provided a baseline in an attempt to obtain these experiences. When looking at the results of this study, they seem to align with the theoretical framework of moral hazard theory. Common response like “crutch” or “insurance policy” or “get out of jail free card” support the idea of an individual acting riskier when they are covered financially (Mirrlees, 1999; Rowell & Connelly, 2012), or in this case, covered criminally and medically. Throughout this study, there was also some support that naloxone led to more opioid-related theft (Doleac & Mukherjee, 2018) such as shoplifting, and/or later arrest for drug possession charges based on the participants’ experiences.

As noted in Chapter 2, New Jersey received federal funding from a federal program called the Enhanced State Opioid Overdose Surveillance (ESOOS) several years ago. In 2019, the New Jersey Department of Health received \$7.4 million in federal grant money to be used by Governor Phil Murphy’s administration to achieve the goals of a “comprehensive approach of linking individuals with substance use disorder to care and treatment, reducing opioid prescribing and improving data collection to better inform initiatives” (N.J. DOH, 2019, para. 1).

Some of the participants' described experiences in workplace procedures of inputting overdose data into a live database may be the result of the ESOOS's stated goals of increasing the timeliness of reporting non-fatal overdoses, fatal overdoses, and disseminating surveillance findings to key stakeholders in order to inform and prevent opioid overdoses ([CDC ESOOS], 2020). Additionally, although this study is only limited to 10 participants and cannot be generalized, it confirmed that naloxone is effective at reversing the effects of opioids (Lavelle, 2014; Wermeling, 2015). The use of naloxone when administered in a timely manner can clearly save lives, is evident in the results and confirms a study by Davis et al. (2013). Finally, this study showed that police officers' attitudes were overall positive in regards to saving lives and the purpose of the NJOPA and naloxone, but a sense of frustration and anger existed among police officers, especially on repeat offenders. This aligned with a study by Green et al. (2013) that showed law enforcement attitudes were that of frustration in regards to the recidivism rates of a drug user.

Recommendations for Policymakers and Police Chiefs

A series of recommendations were made by each participant at the end of the interview. Many recommendations overlapped and were a result of their personal experiences on a drug overdose call after the passing of the NJOPA. From the police officers' perspectives, combined with the researcher's experience and analysis, and specific to New Jersey practices, the following are recommended:

Recommendation #1 – Funding for Preassembled Naloxone

While discussing the naloxone administration with each officer, it was discovered that there seems to be two types of naloxone. One unit has to be assembled carefully with several parts that need to be twisted together. After this, a certain dosage of naloxone is to be

administered into each nostril separately. While on scene and under stress, this assembly can take extra time and leave room for error, delaying faster and proper administration of naloxone. Some participants stated that they have a preassembled naloxone unit, that only requires being opened from the package and administered into one nostril without measuring the dosage. It was recommended by police officers that all naloxone units be preassembled to make the administration faster and less stressful. Although the NJOPA does not currently provide funding, the type of naloxone unit that a police chief purchases or county prosecutor's office recommends to purchase can be made at that level respectively. State or local funding to update each agency with the preassembled naloxone is recommended.

Recommendation #2 - Overdose Victim cannot Refuse Medical Attention (RMA)

Most of the victims that a police officer saved the life of, came to their senses and while still "lethargic" were medically transported to a hospital. However, some participants stated that their policy still allows for a drug overdose victim to refuse medical attention (RMA). It was recommended that if someone is administered naloxone, it should be mandated that they must be transported to the hospital and be medically cleared by a doctor before they are released. It is possible that the effects of naloxone can wear off after the police clear the scene and a person could go unconscious and stop breathing. The National Institute on Drug Abuse states that naloxone works to reverse the effects of an opioid in the body for 30-90 minutes, but opioids can remain in the body after that (NIDA, 2020). Additionally, it was noted that an intoxicated person who is totally inebriated cannot refuse medical attention because he is not in the right state of mind to do what is best medically for himself. The NJOPA should be amended to require all drug overdose victims be transported to the hospital for further medical evaluation. This is also a

change that can be made at the county level through a county prosecutor's directive that would not allow a victim to RMA.

Recommendation #3 - Repercussions of Some Kind (But Not Incarceration)

The majority of participants stated that the NJOPA and use of naloxone is good. However, almost all had a recommendation that involved some type of change involving repercussions after the initial overdose call. Some police officers stated that there needs to be more follow up on the victim after the overdose to ensure that they are okay and seeking some type of treatment. This change can be made at the department level by the police chief, but also requires that there are county facilities and treatment options available for the victim. Some police officers recommended that there be a "three strikes" amendment, that states once a person receives naloxone three times, they should be charged criminally. This can only be done at the state level by policymakers amending the NJOPA. Finally, some police officers recommended that the overdose victim should be given a court date and follow a drug rehabilitation program which may include weekly drug testing, in lieu of being charged criminally. In this case, all pending criminal charges will be dropped upon successful completion of the program.

Based on the lived experiences of all the participants, they believed that some type of repercussion should be in place for the victim after an overdose call; however, no one agreed that the physical placement in jail was appropriate. In order to bring this thought process to fruition, it is my recommendation that all drug overdose calls be treated similar to medical calls, juvenile calls, or domestic violence calls, where the victim can have their identify protected to some degree by either the use of their initials or "Jane/John Doe" listed in formal documents. In moving forward with this approach, any court appearance that is required by the victim should be done in an "online" fashion, similar to what is being done presently in the midst of COVID-19,

thus, limiting the physical exposure that a victim may receive in public at a courthouse. A link would be sent out to only the person on the docket for that date and time, and the court session would not be viewed by the general public.

Recommendation #4 - Inform the Public of the NJOPA

Police officers felt that the NJOPA and naloxone are achieving their goal of saving lives. However, some felt that the average person in New Jersey might not know that a person can't be charged, which may still cause fear and reluctance for someone to call 911. This recommendation can be done at already established needle exchange programs in New Jersey, or "Syringe Access Programs" which exist in seven major cities (Asbury Park, Atlantic City, Camden, Jersey City, Newark, Paterson, and Trenton, (N.J. DOH, 2020)). Moreover, the drug user or family of a drug user who is experiencing this for the first time may need to be made aware of the NJOPA through other means, such as highway billboards or public service announcements.

Recommendation #5 – Training in Police Academy/Agency Accreditation

Four police officers in this study were hired after the NJOPA was signed into law. All four participants stated that they received no formal training on the NJOPA in the police academy. The history and reasoning behind this law, and possibly how to approach and handle the scene, should be taught in the police academy. Education about the NJOPA to new police officers while still in the police academy may result in a positive emotional response from them when they encounter their first real life drug overdose call in the field.

Moreover, during data analysis, it was discovered that police officers who worked for an accredited agency appeared to have better policies and procedures in place, resulting in a more knowledgeable police officer and uniformed practices. The New Jersey State Association of

Chiefs of Police approves local police department accreditation in New Jersey. According to their website, “accreditation is a progressive and time-proven method of assisting law enforcement agencies to calculate and improve their overall performance” (NJSACP, 2020, para. 1). Therefore, it is recommended that if feasible, all police departments within the State start the process of accreditation. This might help the agency combat the opioid epidemic more effectively, as well as other areas in policing.

Recommendation #6 – Annual Professional Development Training

As shown above, senior police officers, and even junior police officers, can have a negative or “cynical” view about responding to a drug overdose call. Some police officers expressed a poor attitude or neutral attitude about saving the life of a repeat drug overdose offender. As a public servant, the police officer should try to hold the same level of positivity regardless of whose life is being saved. Realizing that police officers are human and that it may be difficult to shape how a person feels internally, annual professional development training or sensitivity training is recommended to help maintain the same positive attitude that a new police officer has when he/she is first hired. It was noted in this study the difference in morale between a senior officer and junior officer. Years of service and being a “post-NJOPA” police officer played a role in the attitude of the police officer, but this may also be due to their chronological age difference. A junior police officer may have grown up during the opioid epidemic and may have seen the problems that opioids present as opposed to a senior police officer that has not been impacted personally by the opioid epidemic.

Recommendations for Further Study

One of the reasons this topic of study was chosen by this researcher was because of the limited number of phenomenological studies of police officers in general, as well as of the

NJOPA and use of naloxone on drug overdose scenes in the State of New Jersey. Although this study will help supplement existing literature on GSLs and naloxone use, additional research could be valuable in helping policymakers and police chiefs understand the experiences of a patrol officer. Below are recommendations for further study:

Recommendation #1 - Police Mental Health Longitudinal Study

Repeated words by the majority of police officers included “callous” and “numb” when describing their emotions about administering naloxone and responding to a drug overdose. Police officers experience much stress in their job and often prioritize responding to other people’s needs over their own in their personal life. It is important that the mental and physical health of a police officer is evaluated over the course of their career. As a result, this researcher recommends a longitudinal study on police officers from when they start their career, possibly done in the police academy, until at least 15 years on the job (most years by a participant in this study) to see the changes over time caused by a police officer’s lived experience.

Recommendation #2 – Same Study in a Different Site Location within New Jersey to include Female Police Officers

Because of the nature of this study, it cannot be generalized to a larger population. Additionally, one participant worked in a major city in south New Jersey known for its extreme crime and drug use. Although his experiences within that agency were not included as part of the data analysis, they were still noted by this researcher. In order to gain a better understanding of the lived experience of more police officers throughout the state, this researcher recommends the same type of study, but in a different site location and with the inclusion of female police officers. This might capture similar or unexpected experiences compared to this study, which can be further used by policymakers and police chiefs.

Recommendation #3 - Comparison Study between Police Officers in New Jersey Who Responded to a Drug Overdose Call with Police Officers Who Responded to a Drug Overdose Call in a State that Criminally Prosecutes the Overdose Victim.

The lived experiences of police officers in other states that charge an overdose victim criminally should be examined and compared to this study. It would be interesting to gather police officers' opinions on the actions or attitudes of the drug overdose victim, as well as noting their workplace conditions. A perspective from a police officer in a state that still charges an overdose victim criminally may have an influence on policymakers in this state or another state that could lead to implementation or amendments to existing laws.

Recommendation #4 – Phenomenological Study on the Lived Experience of a Drug Overdose Victim who is now Opioid-Free.

Initially, this researcher developed the idea to conduct research on the lived experience of a drug overdose victim. In this researcher's personal experience and conversations, many people who were dependent on drugs became sober because of being jailed. Ironically, one of the recommendations by this researcher based on his lived experiences, as well as the recommendations of most of the participants, is no incarceration for a drug overdose victim. This researcher could not conduct this type of study because of two reasons: 1) drug users are a vulnerable population; and 2) ethical reasons pertaining to this researcher's position of authority as a police officer. Therefore, this researcher recommends a study on an overdose victim's experience of being administered naloxone and who got sober due to either incarceration or another mandatory court order such as drug counseling. This would need to be done by a researcher in a neutral position of authority.

Conclusion

On average, over 115 Americans die every day from an opioid overdose (Rudd et al., 2016; [CDC], 2019). As a result, the philosophy to combat the problem of drug use has changed. Policymakers and politicians across the country have shifted from a hardline punitive approach to a rehabilitative approach in an attempt to save lives (Congressional Documents & Publication [CDP], 2015, 2016; Davis, Webb, & Burris, 2013). Some of the ways that policymakers decided to combat the opioid epidemic through policy was with the implementation of Good Samaritan Laws (GSLs) and the use of naloxone on overdose victims by first-responders. In New Jersey, the NJOPA was signed into law and administration of naloxone by police officers to drug overdose victims became common practice. The purpose of this transcendental phenomenological study was to investigate how police officers in New Jersey described their experience with responding to a drug overdose call since the passing of the NJOPA and use of naloxone.

This study is significant because other studies that address this topic using this methodology are limited and do not provide this unique perspective to these ways of combatting the opioid epidemic. Results showed that there were five main common themes among police officers, which included NJOPA and naloxone, change in police procedures, relationship between police officers' attitudes and their years of service, factors that change the experience of an overdose call, and police officers and overdose victims after an overdose call. Although participants had different experiences on drug overdose calls, all of the police officers acted professionally and saved many lives as a result of their actions. All participants were excited to participate and concluded with valuable recommendations. This study demonstrated that the NJOPA and use of naloxone by police officers appears to be the right step in combatting the

opioid epidemic, but there may be ways to further amend the law that help the victim, the police officer, and society as a whole even better.

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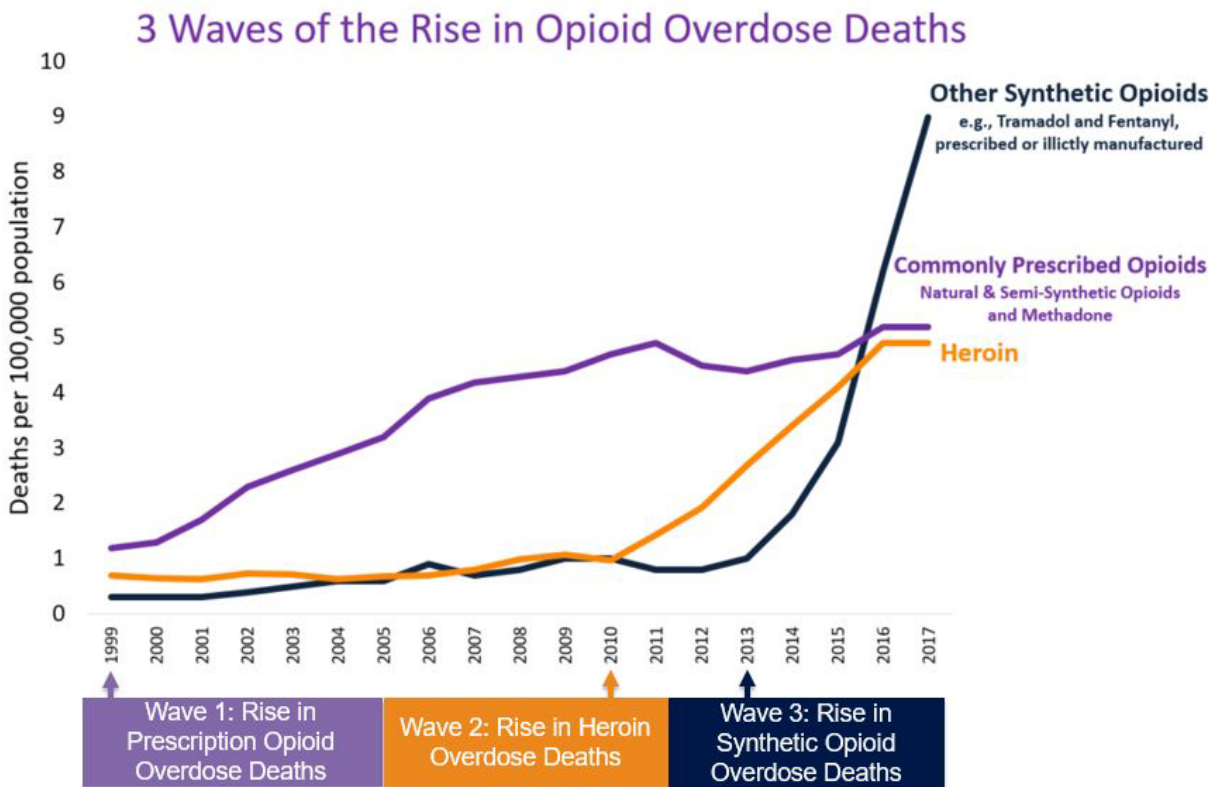
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Appendix A



SOURCE: National Vital Statistics System Mortality File.

Appendix B



CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lieutenant Governor

JOHN J. HOFFMAN
Acting Attorney General

Page 2

TO: All County Prosecutors
All Municipal Prosecutors
All County Sheriffs
All Police Chief Executives
Joseph R. Fuentes, Superintendent
New Jersey State Police
Elie Honig, Director
New Jersey Division of Criminal Justice

FROM: John J. Hoffman, Acting Attorney General

SUBJECT: Directive to Ensure Uniform Statewide Enforcement of the "Overdose Prevention Act"

DATE: June 25, 2013

1. Introduction and Overview

On May 2, 2013, Governor Christie signed into law the "Overdose Prevention Act" as P.L. 2013, c. 46. A copy of the new law is attached. Pursuant to my authority and responsibility under the Criminal Justice Act of 1970, N.J.S.A. 52:17B-97 *et seq.*, to ensure the uniform and efficient enforcement of the criminal laws, I hereby issue this Directive to ensure that all police and prosecuting agencies comply with the requirements of the new law.

The provisions of the Overdose Prevention Act that are most relevant to law enforcement officers and agencies are codified at N.J.S.A. 2C:35-30 and 2C:35-31. The overarching purpose of the statute is to encourage persons to seek immediate medical assistance whenever a drug overdose occurs. In the past, there have been instances where persons were reluctant or unwilling to call authorities for help for fear that this might lead to an arrest or prosecution for illegal drug use or possession. It is vitally important that medical assistance be rendered as quickly as possible to



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3. Crimes That Are Not Subject to the Statutory Immunity Feature

It is important to note that the immunity from arrest, prosecution, and conviction afforded under the statute applies only to those crimes and offenses that specifically are enumerated in N.J.S.A. 2C:35-30(a)(1-6) and 2C:35-31(a)(1-6), and that are comprehensively set forth in Section 2 of this Directive. These specified drug-related offenses commonly are referred to as "simple possession" offenses. It is critical to note that the statute does not apply to or in any way limit the authority or discretion of law enforcement officers or prosecutors to investigate, arrest or prosecute an offense involving the manufacture, distribution, or possession with intent to distribute an illicit substance or paraphernalia. The legislative findings set forth in the statute make clear in this regard that, "[i]t is not the intent of the Legislature to protect individuals from arrest, prosecution or conviction for other criminal offenses, including engaging in drug trafficking..." N.J.S.A. 24:6J-2.

Nor does the statute preclude an arrest, prosecution or conviction for the crime of strict liability for drug-induced death in violation of N.J.S.A. 2C:35-9, or the offense of driving while under the influence of an intoxicating substance in violation of N.J.S.A. 39:4-50 or any related drunk/drugged driving offense or indictable crime.

4. Uniform Statewide Enforcement Policy Where Multiple Persons Collaborate in a Request for Medical Assistance

The literal text of the statute affords immunity only to the specific individual who actually sought medical assistance (e.g., the person who placed a 9-1-1 telephone call) and to the person who experienced a drug overdose and was the subject of a good faith request for medical assistance made by another. There may be situations, however, where two or more persons are present when the request for medical assistance is made. Consistent with the spirit of the law and its overriding purpose to reduce disincentives to seeking prompt medical help, where it can reliably be determined that two or more persons were present at the time that the request for medical assistance was made and were aware of and participating in that request, police and prosecutors should proceed as if those persons had collaborated in making the request for medical assistance, even though only one of them actually placed the call to the 9-1-1 emergency system or otherwise made the request for medical assistance. Persons who in this manner collaborated in making the request for medical assistance should not be arrested or prosecuted for an offense enumerated in Section 2 of this Directive.

This enforcement policy, while arguably not required by the literal terms of the statute, is hereby adopted for sound policy reasons. Persons present at the scene of a drug overdose might be chilled from making a request for medical assistance for fear that such a call to authorities might subject friends, family, or colleagues to arrest or prosecution for drug use or possession. It therefore makes sense to refrain from arresting and/or prosecuting persons who reasonably appear to be associated and collaborating with the person who actually places the call for medical help. This policy is not intended, however, to insulate from arrest and prosecution all persons who happen, for

persons who are experiencing a drug overdose. The Governor and Legislature have thus determined that lives can be saved by alleviating the fear of arrest and prosecution that might discourage or delay a call for help. To accomplish this vital goal, the new law provides legal protection in the form of immunity from arrest, prosecution, or conviction for a use or simple possession drug charge when a person, in good faith, seeks medical assistance for him/herself or for another. The request for medical assistance that triggers the law's immunity feature may be made by means of the 9-1-1 telephone emergency system or by any other means.

In order to achieve the salutary goal of the Drug Overdose Prevention Act, all law enforcement officers and prosecutors must be familiar with the new law and take steps to ensure that the legal protections afforded under the statute are respected and uniformly enforced throughout the State.

2. Specific Crimes and Offenses That Are Subject to Immunity From Arrest and Prosecution

The Overdose Prevention Act specifically provides that when a person, in good faith, seeks medical assistance for a person believed to be experiencing a drug overdose, whether the person is seeking assistance for him/herself or for another, the person calling for help and the person experiencing the overdose shall not be arrested, charged, prosecuted, or convicted for certain specified criminal offenses. The specified crimes and offenses are as follows:

- 1) obtaining, possessing, using, being under the influence, or failing to make lawful disposition of any controlled dangerous substance or analog in violation of subsection a., b., or c. of N.J.S.A. 2C:35-10;
- 2) inhaling the fumes or possessing a toxic chemical in violation of subsection b. of N.J.S.A. 2C:35-10.4;
- 3) using, obtaining, attempting to obtain, or possessing any prescription legend drug or stramonium preparation in violation of subsection b., d., or e. of N.J.S.A. 2C:35-10.5;
- 4) acquiring or obtaining a controlled dangerous substance or analog by fraud in violation of N.J.S.A. 2C:35-13;
- 5) unlawfully possessing a controlled dangerous substance that was lawfully prescribed or dispensed in violation of N.J.S.A. 2C:35-24; and
- 6) using or possessing with intent to use drug paraphernalia in violation of N.J.S.A. 2C:36-2, or having under control or possessing a hypodermic syringe or other instrument for using a controlled dangerous substance or analog in violation of subsection a. of N.J.S.A. 2C:36-6.

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example, to be in a "crack house" or at a party at which a person experiences an overdose. Rather, it is intended to apply only to those individuals who were aware of and collaborated in the request for medical assistance. For example, police should refrain from arresting a person who was aware that someone else had placed a 9-1-1 call for medical assistance and stayed with the person who was experiencing an overdose until help arrived. This enforcement policy would also apply where a person can demonstrate that he or she left the presence of the overdose victim for the purpose of seeking medical assistance, such as by going to a neighbor's house to make a 9-1-1 call. It would not apply, however, to those who flee the scene to avoid apprehension without collaborating in a good-faith effort to seek medical assistance, or to any person who had in any way or by any means discouraged others from making a call for assistance.

This enforcement policy is intended to effectuate the goal of encouraging persons to initiate timely requests for medical assistance to the greatest extent feasible. It must be recognized that as a practical matter, police investigating an incident may not be able to establish who is entitled to immunity from arrest and prosecution under the statute (e.g., who placed a 9-1-1 call), much less to establish who may have collaborated in the request for medical assistance for purposes of applying the foregoing enforcement policy. Law enforcement officers and prosecutors are expected to apply the law and this enforcement policy in good faith, recognizing that for practical reasons, persons who seek the benefit of the law's immunity feature must bear responsibility for establishing the factual basis for immunity from arrest or prosecution.

Nothing herein shall be construed to create any rights, privileges, or immunities beyond those expressly established in the Overdose Prevention Act. Nor does the enforcement policy established in this section in any way limit the authority of prosecutors to argue in litigation that the statutory immunity feature does not apply to any individual.

5. Inapplicability of Statutory Immunity When Offense Is Discovered Independent of a Request for Medical Assistance

The immunity provisions of the statute apply only when the evidence for an arrest, charge, prosecution or conviction had been obtained as a result of the seeking of medical assistance. N.J.S.A. 2C:35-30(b)(2) and 2C:35-31(b). The immunity feature thus does not extend to simple possession drug offenses that come to the attention of law enforcement by any independent means. Thus, for example, a prosecution for a simple possession drug offense may proceed if the evidence of that offense had been discovered and seized prior to the call for medical assistance (e.g., where police during an encounter see a controlled dangerous substance in plain view and a person on the scene thereafter tells police that he/she or another person is experiencing an overdose and needs medical assistance).

6. Authority to Seize Contraband Even When Immunity Feature Applies

The statute makes clear that it in no way limits the authority of law enforcement officers to seize evidence or contraband, even if the person from whom the evidence was seized is immune from arrest or prosecution for possession of that evidence or contraband. See N.J.S.A. 2C:35-30(c) and 2C:35-31(c).

7. Effective Date and Application to Pending Cases

The new law took effect immediately upon its enactment on May 2, 2013. Any pending prosecution for a covered offense should be dismissed on motion of the prosecutor in any case where the evidence necessary to prove the offense had been discovered or learned about as a result of a good faith call for medical assistance, notwithstanding that the arrest occurred before the effective date of the statute. It is important to note in this regard that the law clearly precludes not only an arrest, but also an ensuing prosecution or conviction. However, any other pending charges relating to evidence seized before May 2, 2013 (e.g., distribution or possession with intent to distribute charges) are not affected by the new law, and such prosecutions involving charges that are not specifically enumerated in N.J.S.A. 2C:35-30(a) or 2C:35-31(a) should be pursued in the normal course.

8. Questions and Controversies

Any questions by police officers or agencies or municipal prosecutors concerning the meaning or implementation of the Overdose Prevention Act should be directed to the appropriate County Prosecutor. Any questions by County Prosecutors concerning the statute should be directed to the Director of the Division of Criminal Justice, or his designee.

If a court invokes the statutory immunity feature over the prosecutor's objection (*i.e.*, in circumstances where the feature should not apply according to the explanation of the law provided in this Directive), the municipal or county prosecutor shall, through the appropriate chain of authority, promptly alert the Director of the Division of Criminal Justice or his designee and should take such actions as may be necessary to preserve the State's right to appeal the decision.



John J. Hoffman
Acting Attorney General

c. Thomas R. Calcagni, First Assistant Attorney General
Lee Vartan, OAG Chief of Staff

Appendix C

PARTICIPANT RECRUITMENT ANNOUNCEMENT

Fellow First-Responders,

I am seeking your help by your voluntary participation for my doctoral research study on the lived experiences of police officers and paramedics who have responded to a drug overdose call since the passing of the New Jersey Overdose Prevention Act. This is the initial participant recruitment announcement and certain selection criteria will apply. This research study will satisfy the dissertation requirements for a degree in Educational Leadership with an emphasis on Transformative Leadership as part of the Doctor of Education program at the University of New England.

There is ample amount of research on the topic of opioids and different approaches to combat the “opioid epidemic” which include Good Samaritan Laws (GSLs) and the use of naloxone by first responders. However, limited research has been conducted on the perceptions of the police and paramedics who actually administer naloxone to an overdose victim who then does not get charged criminally. Specifically, this study will focus on how police and paramedics perceive the New Jersey Overdose Prevention Act and uncover their lived experiences when responding to a drug overdose call. The information gathered from this study can add to the academic literature, as well as provide essential information to policymakers and politicians who are considering implementing or amending GSLs or naloxone policies in their respective districts.

Selection criteria for participation in this study include the following:

1. Participant is either a full time sworn police officer or paramedic
2. Participant works within the State of New Jersey
3. Participant has responded to a drug overdose call
4. The overdose call was after the passing of the New Jersey Overdose Prevention Act in 2013 and it required the use of naloxone by the police officer or paramedic
5. Participant is willing to be audio recorded for an interview lasting between 30-45 minutes

Participation in this study is voluntary. Once a participant who meets the selection criteria expresses a desire to participate, I will conduct the interview as soon as possible depending on a mutually agreed upon time. Each interview is expected to last between 30-45 minutes following a semi-structured format. Participant rights and protections will be explained in the Informed Consent Form which will be signed by the participant and researcher. The degree of risk is limited and confidentiality is promised. With that said, confidentiality will be protected to the extent permitted by law. This study was approved by the Institutional Review Board at University of New England. If you have any questions, can contact me via email.

Project Title: New Jersey Overdose Prevention Act: First-Responders’ Experiences At a Drug Overdose

Principal Investigator: Michael Ziarnowski, Researcher (732) 236-3686 or
mziarnowski@une.edu

Thank you for your time and I look forward to working together. If you know someone who meets the above listed selection criteria, please feel free to forward this information to them for consideration.

Sincerely,

Michael Ziarnowski

Doctoral Candidate, University of New England

Appendix D

Semi-Structure Interview Protocol

NEW JERSEY OVERDOSE PREVENTION ACT:
FIRST RESPONDERS' EXPERIENCES AT A DRUG OVERDOSE

Michael Ziarnowski, Researcher

1. Can you tell me the answers to the following questions?
 - a. Age
 - b. Sex
 - c. Highest level of Education
 - d. Agency/County
 - e. Number of years employed as a first responder
 - f. Number of drug overdose calls responded to

The next set of questions is about your experiences as a police officer or paramedic who responded to a drug overdose dose call after the passing of the OPA and use of naloxone:

2. What is your knowledge about the Overdose Prevention Act?
3. What is your knowledge of the use of naloxone by first responders?
 - a. What are your thoughts about this as a means to save lives?
4. Can you describe your workplace environment since the passing of the Overdose Prevention Act?
 - a. How has the workplace environment changed since the passing of the Overdose Prevention Act in regards to:
 - i. Policy, procedure, rules, and regulations
 - ii. Attitude and morale
5. What feelings do you recall from your last experience administering naloxone on a drug overdose call?
 - a. What was the victim's outcome?
6. Can you describe the behavior of a drug overdose victim since the passing of the Overdose Prevention Act and use of naloxone?
7. What suggestions or recommendations do you have for any policymakers regarding the Overdose Prevention Act and use of naloxone?
8. Is there anything else you would like to add?

Appendix E



Appendix F

E. Informed Consent**INFORMED CONSENT**

Project Title: New Jersey Overdose Prevention Act: First Responders' Experiences At a Drug Overdose

Principal Investigator: Michael Ziarnowski, Researcher 732-236-3686 or mziarnowski@une.edu.

Faculty Advisors: Michelle Collay, Ed.D. 207-602-2010 or mcollay@une.edu
Kimberly Roberts-Morandi, Ed.D. 207-221-4960 or krobertsmorandi@une.edu

Introduction:

- Please read this form, you may also request that the form is read to you. The purpose of this form is to provide you with information about this research study, and if you choose to participate, document your decision.
- You are encouraged to ask any questions that you may have about this study, now, during or after the project is complete. You can take as much time as you need to decide whether or not you want to participate. Your participation is voluntary.

Why is this study being done?

- The purpose of this study is to understand the common lived experiences of first responders who have responded to a drug overdose call since the passing of the New Jersey Overdose Prevention Act and examine common themes among them, and specifically, their perceived effectiveness, that may contribute to the literature in the opioid epidemic topic.
- The researcher does not have a consultative or financial interest related to conducting this study. This study is solely for the purpose of adding to the existing literature while satisfying the Doctor of Education Degree dissertation requirements of the University of New England.

Who will be in this study?

- Full-time sworn police officers or certified paramedics within the State of New Jersey
- All participants must be 18 years old to participate
- All participants must have responded to a drug overdose call and administered naloxone since the passing of the New Jersey Overdose Prevention Act
- A minimum of 8 participants and a maximum of 14 participants will be selected from the total study population for individual interviews, with a stratified sampling technique to achieve an equal number of police officer and paramedic participants

What will I be asked to do?

- If selected for a semi-structured individual interview, you will be contacted by the researcher, asked to complete the Informed Consent Form, and interviewed in a manner that you feel comfortable with (i.e., in-person, web conference) at a mutually convenient time lasting approximately 30-45 minutes.

- Interview responses will be recorded and transcribed by the researcher, or a professional transcription service, (Rev.com, a professional online transcription service that ensures confidentiality and encryption of data) and then analyzed by advanced coding software (dedoose.com or ATLAS.ti). Recurring themes will be analyzed to the fullest extent to gain a holistic perspective of the viewpoints of police officers and paramedics who have responded to a drug overdose call since the passing of the New Jersey Overdose Prevention Act.
- You can skip or refuse to answer any question for any reason.
- You will sign the informed consent form and a copy will be provided to you.
- The principal investigator will be the only person collecting the data recordings to ensure the confidentiality of the participants and to provide uniform collection procedures. All data will be kept only on a personal home computer, password protected and accessed by only by the principal investigator, with a back-up USB flash drive on site. Identifiable data will be omitted from the dissertation texts and results will be summarized based on participant responses. Individual responses will be reported without the use of the participants name's or institutional affiliations and will not be accessible for use in future studies.
- A copy of the transcribed interview will be provided to you in order to member check the accuracy of the information shared. All codes and themes developed from the interview will be shared with you.

What are the possible risks of taking part in this study?

- The direct risks are minimal to none to you.
- There may be the highly unlikely instance where a response by the participant demonstrates a time when the first responder did not legally do their job. If the principal researcher recognizes that you feel embarrassed or uncomfortable during a question, he will remind you to take your time and reflect on your answer before providing it.
- All participants' identifiers will be kept confidential, and you can refuse to answer any question at any time.
- Confidentiality will be protected to the extent permitted by the law.

What are the possible benefits of taking part in this study?

- There are no direct benefits to you for taking part of this study. However, self-reflection can occur and you may view your role as a first responder affected by the New Jersey Overdose Prevention Act in a different way.
- Data collected may provide more valid, informational accounts of the lived experiences of first responders who responded to a drug overdose call since the passing of the New Jersey Overdose Prevention Act, which could add to the academic literature to be used by other scholars, and to be used in consideration by policymakers and politicians when created new laws relating to the opioid epidemic.

What will it cost me?

- There is no cost to you for contributing to this study.

How will my privacy be protected?

- All of your identifying information obtained throughout the entire process will be kept confidential and only known by the principal investigator.
- Only the principal investigator will have access to the identity of you. All research records will be kept in a locked safe in the home office of the principal investigator.
- As an added provision of privacy, your identity will not be revealed at any time and pseudonyms will be assigned (i.e. Participant #1).
- Names and places of employment will not be shared with anyone.
- Any audio recording will be protected in compliance with the University of New England's research with human participants' policies and procedures.

How will my data be kept confidential?

- The recordings of the interview will be electronically stored and password protected. Only the researcher and faculty advisor will have access to the recordings, which will be deleted upon interview transcription.
- Data collected will be given a random numerical code to maintain confidentiality of individually identifiable interview transcripts and recordings. Research data will be physically destroyed or erased after the dissertation is completed and has been deposited in the institutional repository of the University of New England.
- Regulatory agencies and the Institutional Review Board may review the research records. A copy of your signed consent form will be maintained by the principal investigator for at least three years after the project is complete before it is destroyed.
- Consent forms will be stored in a locked safe inside the home office of the principal investigator. You will be informed of any significant findings developed during the course of the research that may affect your willingness to participate in the research.

What are my rights as a research participant?

- Your participation is voluntary. Your decision to participate will have no impact on your current or future relations with the University of New England.
- You may skip or decline to answer any question at any time.
- You may withdrawal from the study at any time.
- There is no penalty for not participating.

Whom may I contact if I have questions?

- The researcher conducting this study is Michael Ziarnowski, Principal Investigator (PI). For questions or more information concerning this research study, you may contact Michael Ziarnowski, PI at 732-236-3686 or mziarnowski@une.edu.
- The lead faculty advisor for this study from the University of New England is Michelle Collay, Ed. D. She may be contacted at 207-602-2010 or mcollay@une.edu.

Participant's Statement

I understand the above description of this research and the risks and benefits associated with my participation as a research subject. I agree to take part in this research and do so knowingly, voluntarily, and intelligibly.

Participant's Signature (electronic is accepted)

Date

Printed Name

Researcher's Statement

The participant named above had sufficient time to consider the information, had an opportunity to ask questions, and voluntarily agreed to be in this study.

Researcher's Signature

Date

Printed Name

Appendix G



UNIVERSITY OF
NEW ENGLAND

Institutional Review Board
Mary DeSilva, Chair

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To: Mike Ziarnowski

Cc: Michelle Collay, Ph.D.

From: Lliam Harrison, M.A., J.D. CIM

Date: February 14, 2020

Project # & Title: 20.01.21-013 New Jersey Overdose Prevention Act: First Responders' Experiences At a Drug Overdose

The Institutional Review Board (IRB) for the Protection of Human Subjects has reviewed the materials submitted in connection with the above captioned project and has determined that the proposed work is exempt from IRB review and oversight as defined by 45 CFR 46.104 (d)(2).

Additional IRB review and approval is not required for this protocol as submitted. If you wish to change your protocol at any time, including after any subsequent review by any other IRB, you must first submit the changes for review.

Please contact Lliam Harrison at (207) 602-2244 or wharrison@une.edu with any questions.

Sincerely,

William R. Harrison, M.A., J.D. CIM
Director of Research Integrity

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Submission Date: 01/21/20
Status: Exempt, 45 CFR 46.104 (d)(2)
Status Date: 2/14/20